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MINIMUM HEALTH BENEFITS FOR ALL WORKERS ACT OF 1987

HEARINGS

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

ON

S. 1265

TO AMEND THE PUBLIC HEALTH SERVICE ACT AND THE FAIR LABOR STANDARDS ACT OF 1938 TO PROVIDE MINIMUM HEALTH BENEFITS FOR ALL WORKERS IN THE UNITED STATES

NOVEMBER 4, 1987

PART 2

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MINIMUM HEALTH BENEFITS FOR ALL WORKERS ACT OF 1987

WEDNESDAY, NOVEMBER 4, 1987

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The Committee met, pursuant to notice, at 10:06 a.m., in room SD-430, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman) presiding.

Present: Senators Kennedy, Hatch, Thurmond, and Quayle.

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. The Committee will come to order.

Millions of Americans face a continuing crisis in obtaining access to the essential health care they need and deserve. According to the Census Bureau, 37 million Americans have no health insurance at all. The number without this basic protection has been increasing by more than one million a year since 1980. Two-thirds of the uninsured are full-time workers or their dependents.

In addition to those without health insurance, millions more have insurance that fails to protect them against the high cost of serious illness. According to the Department of Health and Human Services, 2.4 million families every year have catastrophic out-of-pocket costs for health care that exceed $3,000. More than 70 percent of these families have health insurance, but its protections are inadequate.

Every uninsured and under-insured American is a potential tragedy waiting to happen. One of our highest domestic priorities should be to assure essential health care and health insurance protection to every citizen.

The legislation we are considering today is the most important single step we can take toward that objective. It will provide basic protection to 24 million Americans and their dependents who now have no health insurance at all, and it will assure protection against catastrophic costs to all working families.

This proposal is not back-door national health insurance. It creates no massive Federal bureaucracy, and does not add a dime to the Federal deficit. It simply extends the private, employee-based health insurance system that most of us take for granted to the minority of American workers and their families who have been unfairly left out.

So far in the debate on this proposal, a number of legitimate questions have been raised. Some have expressed concern about its impact on small business. Others are concerned about its effect on America's ability to compete in world markets.

Allegations have been made that this kind of requirement will create additional unemployment and impose excessive burdens on our economy. There are good answers to these questions. By creating a system of private regional insurers for small businesses, this legislation offers small businesses both economies of scale and opportunities to participate in cost-effective care systems such as PPOs and HMOs. These innovations can reduce the cost of health insurance to small business by an estimated 25 percent or more.

And for the first time, no small business will be denied the opportunity to purchase insurance because the owner or an employee is in poor health. A plan that reduces the cost of health insurance to small business and guarantees its availability is a plan that small business can live with and prosper under.

On the issue of competition, we are all concerned about America's ability to compete in world markets. The fact is that this plan helps, not hurts, export-sensitive businesses. Ninety-seven percent of all manufacturing workers are employed by companies that provide health insurance coverage. These firms pay too much to insure their workers because other employers who do not face foreign competition pay too little.

Finally, the cost of this plan is modest and reasonable. The CBO testimony today will estimate the value of the new coverage purchased as a result of this legislation at $27 billion. This estimate does not take into account offsets that could bring the net cost of the plan down to approximately half as much. This net amount is less than four-tenths of one percent of total wages in our economy and represents an increase in national health care costs of less than 3 percent.

Put another way, the cost of the coverage is less than 45 cents an hour, equivalent to a 13 percent increase in the minimum wage.

It is for these reasons that analysis of this plan, using two leading econometric models, indicates a minimal impact on unemployment and inflation.

There is no "free lunch" in health care or any other Federal program. The plan has a cost. The question is whether the cost is reasonable compared to the cost imposed on the Nation today by 24 million Americans who have no health insurance.

America is richer today, not poorer, because past Congresses recognized similar needs and enacted Fair Labor Standards, the minimum wage, Social Security, and Medicare. The time has come to take the next great step. Twenty-four million working men and women and their families are waiting for our answer.

Our panel of expert witnesses today is a diverse group with diverse views on the cost of this legislation. But I believe the weight of the evidence will make clear the price tag is affordable, and the benefit is substantial.

The Senator from Utah.

OPENING STATEMENT OF SENATOR HATCH

Senator HATCH. Thank you, Mr. Chairman.

Recently, Mr. Anthony Gajda wrote an article published in the Wall Street Journal entitled, "Insuring all Employees Could Kill the Company." He concluded by saying that workers deserve to know how much the proposal in S. 1265 to provide needed health insurance for all Americans will actually cost. I whole-heartedly agree.

I think it will enhance the discussion today if we remember where our health care system is today.

Eighty-five percent, or more than 200 million Americans, have health care coverage.

Nine out of ten employees under 65 have employer group health coverage.

Fifteen percent of all Americans are uninsured, and that includes one million who are uninsurable because of bad health.

The employed uninsured range widely in age, income, and general health status.

And uncompensated health care costs range between $7 and $8 billion.

We know, however, that some percentage of the 37 million Americans who are uninsured may need or want health insurance. Now, to address this concern, S. 1265 would force a single Federal system on all employees.

What is the expected cost of this program? According to the Congressional Budget Office, it will cost approximately $28 billion, or roughly $350 more per worker.

Who is going to pay for this program? The answer is: Employees. They will pay for it through their own paycheck, through reduced wages, reduced benefits, and reduced work hours.

Can an employee opt out of this program if he or she needs to spend the money on something else, or if they are already covered under another program? No. Under this approach, employees lose their freedom to choose how to spend their own money.

This legislation explicitly excludes any freedom to choose among, for example, cash benefits or leave benefits or life insurance benefits. Some employees may even lose the flexibility of choosing a job as more and more employers are forced to lay off workers in order to meet higher benefit costs.

In addition, S. 1265 presents us with a regressive payroll tax. Highly-compensated employees generally have rich benefit packages that represent a small percentage of their total salary. However, less-skilled workers at a lower pay scale will be forced to pay a greater portion of their salary for this benefit.

Finally, this legislation poses another economic problem, imposing a brand new cost on our society of $25 to $100 billion. This comes at a time when we are trying to balance the Federal budget by looking for $30 billion in spending cuts—or revenue increases.

We are also scurrying to stave off further market spins, and we are trying to make strides at improving our ability to compete in foreign markets.

It seems to me we cannot afford to impose $25 to $100 billion in new taxes, really—it is a hidden tax—in new costs upon our citizens. This still could be the single largest regressive tax imposed on our Nation's citizens.

I would like to demonstrate what I believe this legislation means in real terms. Let me just go to these charts.

This first chart is entitled, "Disposable Income Used for Health Insurance in 1985." The total disposable in come in our country amounts to $2,841,100,000,000. Total health insurance premiums amount to $139 billion. The number of individuals insured is 167 million.

The average premium in 1985 was $833.28, and the percent of disposable income came to 4.91 percent—a little less than 5 percent.

The second chart is disposable income used for health insurance in 1985 under S. 1265. This compares the cost of S. 1265 to what our present system. Again, total disposable income, almost $3 trillion. The average premium, according to Senator Kennedy's figures, will be $1,186. The average premium in 1985 dollars of today's premium so that we make the charts correspond to each other, would be $1,067. The number of individuals insured would be the same. The increase in insured by Senator Kennedy's estimate would be 24 million. The total number insured, then, would be 191,441,000. The total health insurance premiums when added together will be $204,344,123,400.

So the percent of disposable income for health insurance premium jumps from 4.9 percent to 7.19 percent with this bill. And employees are going to pay for this.

The shift in disposable income under S.1265 translates in this next chart. The increase as a percentage of 1985 disposable income would be another 2.28 percent in additional costs to employees. The loss of discretionary income in 1985 dollars is $64 billion. The loss of discretionary income in 1988 dollars is $71.3 billion.

Finally, you talk in terms of disposable income. Here is your medical insurance right now, taking 4.9 percent of one's disposable income. Where are you going to get this extra percentage, or 2.3 percent? Out of other medical expenses? Out of charity? It would take all of the charitable donation. Out of food? It would make a dent in the 17.8 percent of food. How about interest? It takes almost all of that. Clothing—6.9 percent? Personal care? That is 1.4 percent. It would do away with that. Housing—14.2 percent. Education, 1.5 percent—that would go. Household operations. And then we have got other here, personal business, 6.1; savings, 4.5; transportation, 12.6; or recreation, 6.5.

If you add it all up, where is it going to come from? It is going to come right from those who work for a living.

What is 2.3 percent? It is a lot of money. It is billions and billions of dollars, to saddle every American with at a time when our economy is going through very difficult times.

Now, I have to say that I respect and appreciate innovative ideas. I have to admit we have gone a long way toward national health insurance with the present programs we have. And, S. 1265 takes us one major step closer. But as you can see, this is not going to be paid for by Government; it is going to be paid for by *individual employees.* And the ones who are going to suffer the most are those on fixed incomes who really do not have anything leftover to pay. And will be forced those on fixed incomes to pay this bill.

Finally, I do not want anyone to believe that we should not do something to increase access to health care in our country. Because I disagree with this proposal does not mean that I do not recognize that we have a problem. And I will not abandon a good effort to help people get affordable health care coverage.

As a matter of fact, I have been looking at many options to remove the barriers to obtaining health care insurance, and if I find one that I think is workable and will truly help the health care marketplace, I am going to support it.

My problem is I cannot really lend any support to a proposal which taxes the working poor. Now, IRET has done another cost estimate—Increase in 1988 Health Insurance Cost in Billions. If you look at the coverage of employers, new coverage would be $29.5 billion; existing coverage is $21.8 billion. And the mandatory duplication would be $36 billion. If you add it up, the totals are $36 billion in new coverage; $16.3 billion in existing coverage that would be added; and mandatory duplication comes to $45 billion, and there would be an additional administrative cost of $2 billion for this particular bill.

If you talk in terms of the estimate of the 1988 Federal tax loss in billions, IRET estimates a revenue loss due to economic effects of this type of a bill of at least $5 billion. Now, you just have to look at all these cost estimates. It is tough to lend support to any proposal which taxes the working poor, reduces jobs in our country, and causes absolute havoc with our health care system in this country.

I believe the Federal Government has a role in many areas, and I have had to adjust my own personal conservative views, as I have served on this Committee, many times. And I have had to admit that I am wrong many times. But I can tell you right now, I do not think I will ever have to admit I am wrong on this bill. And I am worried about this bill. I am worried about this type of legislation, because I think that if we keep pouring on this type of legislation the real loser is the American worker. And, this is only one of mandated benefits package, one bill out of the total mandated benefits package, that the innovators on this Committee would like to force upon the American worker.

Well, I look forward to listening to our witnesses today. I hope they can answer if this bill will benefit society as a whole, but which I think are going to cost very dearly and very much to the average person in our society.

I look forward to listening to our witnesses. Thank you, Mr. Chairman.

The Chairman. Would the Senator give the authority for the figures? Are those the figures provided by the Institute for Research on the Economics of Taxation?

Senator Hatch. The second set of figures entitled "Increase in 1988 Health Insurance Cost in Billions" are provided by the Institute for Research on the Economics of Taxation.

The Chairman. So that is the group that is providing those particular figures.

Senator Hatch. Right.

The Chairman. I think it is important to underline that. We will get into their background and just who they are a little later during the course of the hearing.

We welcome our first witnesses, two distinguished economists who will provide us with an economic overview of the plan from two different perspectives. Thomas Moore is a member of the Council of Economic Advisers. Karen Davis is Professor of Economics at Johns Hopkins and a former Assistant Secretary of Health.

We look forward to hearing from Mr. Moore.

STATEMENTS OF THOMAS G. MOORE, MEMBER, COUNCIL OF ECONOMIC ADVISERS, WASHINGTON, DC; AND KAREN DAVIS, PROFESSOR OF ECONOMICS AND CHAIRMAN, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, JOHNS HOPKINS UNIVERSITY SCHOOL OF HYGIENE AND PUBLIC HEALTH, BALTIMORE, MD

Mr. Moore. Good morning, Mr. Chairman.

The Administration shares your concern for those Americans without health insurance. We wish to work with the Committee to find effective ways that will reduce the number of Americans without health insurance.

While the objective of providing health insurance to workers and their families is well-intentioned, the mandated uniform approach of this bill would have the unintended effects of reducing opportunities for more jobs and higher pay.

The flexibility of our labor markets would be impaired, our competitiveness would be reduced, and growth in employment and output would be weakened.

Government-required health insurance, like required early notification of plant closings, parental leave, and even the minimum wage, are examples of mandated benefits. Mandates raise the cost of labor to employers and change the mix of cash wages and benefits received by employees.

In sum, mandates amount to off-budget taxes on labor. Despite being motivated by the best of intentions, they all make bad economic policy.

In our economy, employment, wages and benefits are largely determined by the market. Firms are disciplined by the marketplace to offer an overall level of compensation and a mix of wages and benefits that will attract a qualified and stable work force.

Firms have every incentive to offer the combination of wages and benefits that is most attractive to their employees.

As a consequence of mandated benefits, employers will adjust their work forces, wages, and existing benefits. Employers with low-wage and minimum-wage workers will respond in the same way to mandated benefits as they would to an increase in the minimum wage, by hiring fewer workers.

From the employer's point of view, this proposal is equivalent to increasing the minimum wage from $3.35 to $3.75–$3.85 per hour—that is using your figures, Senator. The effect will be slower employment growth with disproportionate adverse effects for the working poor and youth, especially black teenagers.

The costs of mandated benefits will be passed along to workers, in reduced wages and existing benefits, and to consumers in higher prices. Ultimately, most of the cost of any mandated benefits will be passed back to employees in the form of lower real wages and reduced nonmandated benefits.

Mandated benefits will also distort work schedules, reducing the ability of workers and employers to choose convenient work hours. For example, requiring health coverage for those who work 17½ hours or more will result in more part-time employees working under 17 hours. Those who would prefer to work 20 to 30 hours will find it difficult to do so.

While large firms are not insulated from the costs of these proposals, the greatest burden of mandated benefits falls on small, labor-intensive businesses. These firms have led the way in creating new jobs. Mandated health insurance is a striking example of how the burden of mandated benefits disproportionately falls on small businesses. Nearly half of all the workers without health insurance are employed in businesses with less than 25 workers.

Mandated benefits not only increase the costs for entrepreneurs planning to form new businesses. Thus, the most competitive, innovative, and fastest-growing sector of our economy will bear the greatest burden. Some small firms will close, and some entrepreneurs will be deterred from forming new businesses.

Mandated benefits damage the competitiveness of our economy and our best prospects for future growth.

Mandated health benefits limit market flexibility and the ability of employees to receive the most attractive combination of wages and benefits at the least cost to employers. When several mandated benefits are imposed as Congress has been considering, together, they significantly raise costs and reduce market flexibility.

It is curious that the proponents of mandated benefits point to Europe as a model. The ability of the American economy to create jobs is the envy of European countries. During the last five years, nearly 14 million new jobs have been created in the United States. Employment growth has been strong for all major demographic groups. Employment has grown by 55 percent for black teenagers; by 37 percent for Hispanics, and by 16 percent for women. This record stands in sharp contrast to the European experience, where unemployment rates are near post-War highs and where youth unemployment is particularly high.

European governments are increasingly aware that the inflexibility of their labor markets due to government mandates has impaired growth in employment and output. Indeed, during the 1980s, many OECD countries witnessed a reversal in policies toward increasing labor or social protection, including unemployment insurance, minimum wages, job security, redundant pay, hiring and firing rules, and other measures that impose constraints or distort incentives in labor markets.

Particular attention has been given to small firms. Given the performance of European economies in recent years and the lessons that have been learned from this experience, it is hard to imagine why the United States, after such recent successes, should imitate their policies. The problems of worker benefits are important and deserve the careful attention of the government and the private sector.

A number of States have undertaken pilot programs, often with private foundation support. The President has decided to take action to improve catastrophic illness insurance protection for the population under age 65 by working with the private sector to educate the public about such insurance, by working with the States to encourage the development of innovations and initiatives, and by directing the Treasury Department to study the impact on catastrophic illness insurance coverage of selected tax policy changes.

The CHAIRMAN. I will give you another minute or so, if you could wind up.

Mr. MOORE. All right. When looking for solutions, let us see beyond good intentions and let us remember that economic growth is critical for raising the levels of the economic well-being of our citizens. Mandated benefits impair labor market flexibility, reduce employment, and distort wages and prices.

Let me add two points that are not covered in my prepared remarks.

This bill would impose significant cost on 14 million State and local government employees. This would mean higher taxes at State and local levels. It would also cover about 3 million Federal workers. The U.S. Government currently pays about 60 percent of the cost of health insurance for Federal employees, and this would have to be increased to 80 percent under the bill. This would raise Federal costs significantly and would be a major hit on our budget deficit.

Thank you.

[The prepared statement of Mr. Moore follows:]

TESTIMONY OF THOMAS G. MOORE
MEMBER, COUNCIL OF ECONOMIC ADVISERS
BEFORE
THE SENATE LABOR AND HUMAN RESOURCES COMMITTEE

NOVEMBER 4, 1987

Good morning Mr. Chairman and distinguished members of the Committee. I would like to present the Council of Economic Advisers' views on mandated benefits and on S. 1265, entitled "Minimum Health Benefits For All Workers Act of 1987."

The Administration shares your concern for those Americans without health insurance, and recognizes the time and effort that your Committee has devoted to this legislation. We wish to work with the Committee to find effective ways that will reduce the numbers of Americans without health insurance.

S. 1265 would reduce the number of uninsured Americans by an estimated 24 million persons, by requiring all employers to provide health insurance to their employees and to pay 80 to 100 percent of the premiums. While the objective of providing health insurance to workers and their families is well intended, the mandated, uniform approach of this bill would have the unintended effects of reducing opportunities for more jobs and higher pay. The flexibility of our labor markets would be impaired, our competitiveness would be reduced, and growth in employment and output would be weakened. In short, Americans would be worse off.

Government-required health insurance, like required early notification of plant closings, parental leave, and even the minimum wage, are examples of mandated benefits. Mandates raise the cost of labor to employers and change the mix of cash wages and benefits received by employees. In sum, mandates amount to off-budget taxes on labor. Despite being motivated by the best of intentions, they all make bad economic policy. However, the Council's biggest concern is that mandated health insurance represents a disconcerting trend to use Government mandates as a policy tool to address social problems. We hope to persuade the Committee to abandon an approach that will ultimately create more problems than it will solve.

Consider in more detail the effects of mandated benefits on employment, wages, and benefits. Remember that in our economy, employment, wages, and benefits are largely determined by the market. Firms are disciplined by the marketplace to offer an overall level of compensation and a mix of wages and benefits that will attract a qualified and stable workforce. Firms have every incentive to offer the combination of wages and benefits that is most attractive to their employees.

Mandated benefits alter the incentives created by the market. As a consequence of these new requirements, employers will adjust their workforces, wages, and existing benefits. Employers with low-wage and minimum-wage workers will respond in the same way to mandated benefits as they would to an increase in the minimum wage, by hiring fewer workers. The Committee estimates that its mandated health benefits proposal will cost employers $0.40 to

$0.50 per hour per employee. The administrative costs aside, from the employer's point of view this proposal is equivalent to increasing the minimum wage from $3.35 to $3.75-$3.85 per hour (or 12 to 15 percent). The effect will be the same as an increase in the minimum wage: slower employment growth with disproportionately adverse effects for the working poor and youth, especially black teenagers.

While mandated benefits are likely to have smaller disemployment effects for more highly paid workers, there is no free lunch for this group either. The costs of mandated benefits will be passed along to workers, in reduced wages and existing benefits, and to consumers in higher prices. These changes may be quite subtle. For example, as a consequence of mandated health benefits, employees may find that periodic wage increases which in the past kept them ahead of the pace of inflation, are now smaller and will find that their real cash wages have begun to erode. Ultimately, most of the cost of any mandated benefits will be passed back to employees in the form of lower real wages and reduced non-mandated benefits.

Mandated benefits will also distort work schedules, reducing the ability of workers and employers to choose convenient work hours. For example, requiring health coverage for those who work 17.5 or more hours will result in more part-time employees working under 17 hours. Those who would prefer to work 20 to 30 hours will find it difficult to do so.

Employees are not the only group affected by mandated benefits. While large firms are not insulated from the costs of these proposals, the greatest burden of mandated benefits falls on small, labor-intensive businesses. Small firms have less flexibility to substitute capital for labor, to alter the work schedules of their employees, and to adjust their wages and product prices to absorb additional costs. Yet, these firms have led the way in creating new jobs. Mandated health insurance is a striking example of how the burden of mandated benefits disproportionally falls on small businesses: nearly half of all workers without health insurance are employed in businesses with less than 25 workers.

Mandated benefits not only increase the costs of existing small firms but also the costs for entrepreneurs planning to form new businesses. Larger firms, for example, which already provide health insurance, will face little additional costs. Thus, the most competitive, innovative, and fastest growing sector of our economy will bear the greatest burden. Some small firms will close and some entrepreneurs will be deterred from forming new businesses. While some larger firms may be better off with less competition, mandated benefits damage the competitiveness of our economy and our best prospects for future growth.

While mandated benefits clearly have adverse effects, it is true that these effects are often very difficult to measure or in some cases are small enough on average to appear tolerable. For example, most careful studies of the effects of the minimum wage would suggest that the adverse employment effects of mandated health benefits would be significant for uninsured full-time young workers and yet would be small for most adults.

However, even for those groups where social costs seem to be small, we must remember that mandated health benefits limit market flexibility and the ability of employees to receive the most attractive combination of wages and benefits at the least cost to employers. When several mandated benefits are imposed, as Congress has been considering, together they significantly raise costs and reduce market flexibility.

In this context, it is curious that proponents of mandated benefits point to Europe as a model. I can not think of a better example for making the case that mandated benefits should not be used to address social problems.

The ability of the American economy to create jobs is the object of envy in European countries. Given the relative performance of the American economy it is easy to see why. During the last five years nearly 14 million new jobs have been created in the United States. Employment growth has been strong for all major demographic groups: employment has grown by 55 percent for black teenagers, by 37 percent for Hispanics, and by 16 percent for women. This record stands in sharp contrast to the European experience where unemployment rates are near postwar highs and where youth unemployment is particularly high. During the current expansion the U.S. economy has created two and one-half times as many jobs as the other six economic summit countries combined. To fully appreciate this accomplishment, consider that the population of the other summit countries is more than one and one-half times the population of the United States.

European governments are increasingly aware that the inflexibility of their labor markets due to government mandates has impaired growth in employment and output. At the Organization for Economic Cooperation and Development (OECD) Ministerial meeting in May, officials agreed on the importance of private incentives for promoting economic growth and on the importance of labor markets unencumbered by distortions. Indeed, during the 1980s many OECD countries witnessed a reversal in policies toward increased labor or social protection, including unemployment insurance, minimum wages, job security, redundancy pay, hiring and firing rules, and other measures that impose constraints or distort incentives in labor markets. Particular attention has been given to small firms because policymakers understand that small firms can often spearhead an expansion in employment. A recent OECD report concludes that these changes reflected concern that the efficient functioning of labor markets may have been impaired by regulations and policies that were aimed at mitigating specific problems, but that were based on too narrow a view of the economic and social effects.

Given the performance of European economies in recent years and the lessons that have been learned from this experience, it is hard to imagine why the United States, after such recent successes, should imitate these policies.

The problems that motivate proposals to mandate worker benefits are important and deserve the careful attention of the government and the private sector. A variety of alternative approaches that would expand health insurance coverage have already been initiated. These include actions by the Federal Government and by a number of States, as well as pilot programs that have been undertaken with private foundation support. The President has decided to take actions to improve catastrophic illness insurance protection for the population under age 65, by working with the private sector to educate the public about such insurance, by working with the States to encourage the development of innovations and initiatives, and by directing the Treasury Department to study the impact on catastrophic illness insurance coverage of selected tax policy changes.

When looking for solutions to the problem of uninsured Americans, let us see beyond good intentions and let us remember that economic growth is critical for raising the level of economic well-being of our citizens. Mandated benefits impair labor market flexibility, reduce employment, and distort wages and prices. None of these consequences is consistent with our goal of promoting sustained economic growth.

Thank you for the opportunity to present the Council of Economic Advisers' views on mandated benefits. If there are any questions, I would be happy to answer them.

The CHAIRMAN. Karen Davis, we look forward to your testimony.

Professor DAVIS. Thank you, Mr. Chairman. If I could enter my longer statement into the record, I will just abstract a few points.

I am delighted to have this opportunity to testify on the economic impact of employer minimum health insurance coverage. It is important to find a solution to the gaps in health insurance coverage where 37 million Americans have no health insurance coverage, over 17 percent of our non-elderly population. This is a number that is growing over time, and these are mostly lower-income people; only 20 percent have incomes more than three times the poverty level.

The uninsured are sicker than other Americans. They are one-third more likely to be in fair or poor health; they are less likely to get care from a physician or a hospital. Two-thirds of the uninsured with serious symptoms such as loss of consciousness, bleeding, or chest pain, did not see a physician because of the financial barriers that the lack of insurance coverage provides. One in five people with high blood pressure did not get a blood pressure check during the year who are uninsured. One in five pregnant women who are uninsured did not get care in the first trimester of pregnancy.

So I think the first thing we have to remind ourselves is that it is important to find a solution to this problem. What are the solutions?

One solution contained in this bill is to require employers to provide minimum health insurance coverage. Mr. Moore indicated he had a number of concerns with that approach. What are the other solutions?

There are basically three: One, cover all of these people by the Federal Government, and increase taxes and Federal spending to do so. Second would be to use public taxes and funds to subsidize purchase of individual insurance privately. We found that that is inefficient. Individual insurance policies run administrative costs at 30 to 50 percent, compared with an experience of 3 to 5 percent for public programs like Medicare and Medicaid. The third alternative would be to tax hospitals and health insurance and use those funds to provide care for the uninsured. Hospitals and health insurance companies would shift that burden onto employers who now provide health insurance for their workers. So those employers would have a double burden, the cost of caring for their own workers, plus an indirect tax that would have them pay for the care of the uninsured. It is clearly more equitable to have a minimum health benefit that all employers provide.

What would be the cost in economic impact of this proposal?

I have some disagreement with the study by IRET that Senator Hatch brought before the Committee today. I believe that study suffers——

Senator HATCH. Excuse me, Karen, if I could interrupt you. The first figures we had on the first four charts came from the Department of Commerce, Bureau of Economic Analysis, with two Kennedy assumptions; we took what Senator Kennedy said were assumptions on the cost of the new premium and the number of new people covered and used his assumptions. The insurance estimate came from the health insurance industry statistical guides.

Professor DAVIS. Well, let me just address the numbers that are there, and I assume I will have a little extra time to do that.

Senator HATCH. Yes. I just wanted to clarify that.

Professor DAVIS. There are two concerns I have with it. First of all, the total cost of the insurance is grossly over-estimated. As I can see those charts you were talking about, $65 to $100 billion in additional health spending. CBO's estimates, which I agree with, are that this is on the order of $25 to $27 billion. So first of all, the cost of the new insurance is grossly over-estimated.

Secondly, it is important to bear in mind the difference between new costs to society and transferred costs. What this bill does is to replace spending that currently occurs, about $5 billion worth, by the Government so it would reduce that spending; it also reduces spending by individuals for individual health insurance and out-of-pocket health expenses.

So when you are looking at the net new burden on disposable income, what you want to look at is the new spending, the new health services, and that is on the order of $5 billion—I understand CBO thinks $10 billion. So that is a much smaller number than the $65 to $100 billion that we have seen in other studies. So we need to look at transferred costs.

I would like to enter into the record if I might a study using the Data Resources Institute econometric model of what the impact of this coverage would be on the economy. This study finds that there would be some loss of jobs, about 100,000 to 120,000 jobs, as a result of mandating insurance coverage on employers, including the effect on minimum wage or low-wage workers. However, even this study over-estimates the extent of the job loss. It does not take into account the new jobs that are created by this $5 to $10 billion worth of new health services. When you spend that money in the health sector, it takes lab technicians and others to provide those services. At a minimum, you are talking about 100,000 new jobs created in the health sector to provide those new services.

It is not surprising that this bill, like most spending bills, would be expansionary, not contractionary. I think this whole issue, that there is going to be a significant net job loss, is a red herring.

Furthermore, it is unlikely that this would have much effect on the international competitiveness. The sectors of the economy that are affected are largely retail trade, service sector, and the construction sector.

We have also had no increase in the minimum wage since 1981, so we are simply redressing a small portion of that. And further, it is unlikely that there would be any inflationary effect of this bill because we currently have substantial excess capacity in the hospital sector from unoccupied hospital beds and a major increase in the supply of physicians.

So in looking at these economic impacts, we are talking about $25 billion of which $5 to $10 billion would be new health spending on a health sector that is $458 billion. So we are talking about a one percent increase in total health spending nationwide. We are talking about shifting the private share of that spending from 59 percent to 60 percent and reducing the public share somewhat. We are talking about reducing direct out-of-pocket spending from 28 percent of the health bill to 26 percent of the health bill.

So we are talking about something that has a modest economic impact on the health sector, a modest economic impact in terms of jobs, inflation and international competitiveness.

What do we get in exchange for this small effect?

We get coverage of over 24 million uninsured workers and their families, dropping the number of uninsured from 37 million to 13 million. This would provide much-needed improvement and access to health care for a largely low-income population. It would help reduce the intolerable delay in obtaining needed health care for pregnant women, children, those with chronic health problems such as hypertension and diabetes, and those with life-threatening symptoms such as bleeding, chest pain, and loss of consciousness, which many uninsured now experience.

A balanced assessment suggests that mandating employer coverage for workers and their families would be the least disruptive and fiscally burdensome approach to helping those to close the gaps in health insurance coverage of Americans. It deserves serious consideration.

Thank you.

[The prepared statement of Professor Davis and responses to questions submitted by Senator Hatch follow:]

THE ECONOMIC IMPACT OF EMPLOYER MINIMUM HEALTH INSURANCE COVERAGE

Karen Davis

Thank you, Mr. Chairman, for this opportunity to testify on the economic impact of employer minimum health insurance coverage. Gaps in employer-provided health insurance pose significant barriers to needed medical care and undermine the health and economic security of many working families. Requiring employers to provide minimum health insurance coverage to workers would markedly reduce the ranks of the uninsured, improve access to health care, and relieve the financial hardship of health care bills for 24 million Americans.

Today, I would like to review the health and economic consequences of failing to close the gaps in health insurance coverage, as well as discuss how the cost of health care would be distributed under a mandated employer health insurance plan. The economic consequences, including any potential effect on employment, of a minimum employer plan deserve careful consideration and I am pleased to share with the Committee my own analysis of this aspect of the plan.

The Uninsured and Health Care

As previous hearings have documented, 37 million Americans, or about 17.6 percent of the nonelderly population, do not have any health insurance coverage.

Particularly disturbing is the fact that the ranks of the uninsured are growing. In 1980, 30 million Americans, or 15 percent of the nonelderly population, did not have health insurance coverage. Today there are 7 million more Americans without health insurance coverage than was the case six years ago.

The common impression is that the uninsured are outside the work force -- mostly young adults who have not yet found jobs. This is not the case. Surprisingly, over half of the uninsured, 19.6 million people, are in families where at least one member has a full-time job working 35 or more hours per week. Seventy percent of all the uninsured are in families where at least one member works at least 10 or more hours per week. The remaining 30 percent are unemployed or out of the labor force.

Nearly all of the uninsured have modest incomes. About one-third have incomes below the poverty level. Only 20 percent have incomes greater than three times the poverty level. Individual purchase of private health insurance is not economically feasible for most of the uninsured. Individual plans typically have inadequate benefits and charge premiums well in excess of actual benefit outlays. A spell of illness, hospital episode, or chronic health problem incurred by the uninsured can be financially devastating.

Recent studies document the seriousness of absence of health insurance coverage for access to health care. A new report on access to health care in 1986 recently released by the Robert Wood Johnson Foundation contains evidence on the deterioration in access to health care in the 1980s. Thirteen and one-half million people reported not receiving medical care for financial reasons. An estimated one million individuals actually tried to obtain needed care but did were turned away.

The Robert Wood Johnson Foundation access survey found particular problems for the uninsured. The uninsured are one-third more likely to be in fair or poor health than the nonelderly insured. Yet despite their poorer health status, the uninsured receive 27 percent fewer physician services and are hospitalized 19 percent less frequently than the insured. One-fifth of the uninsured with chronic illness did not see a physician during the year. Fully two-thirds of the uninsured with serious symptoms (e.g. bleeding, loss of consciousness, chest pain, shortness of breath, weight loss unrelated to diet) did not see or contact a physician. One-fifth of uninsured pregnant women did not receive care in the first trimester of pregnancy. Twenty-two percent of the uninsured with hypertension did not receive a blood pressure check in the year.

Clearly, absence of health insurance coverage is not only a serious financial problem it is a health problem as well. Millions of Americans are at risk of death and disability because of an inability to pay for needed health care.

Alternative Approaches to Closing the Gaps in Health Insurance Coverage

It is urgent that action be taken to provide at least some minimum essential health insurance coverage for all Americans. In evaluating the economic impact of any one approach to dealing with this problem, it is important to consider the alternatives. The major approaches which could be followed to close the gaps in health insurance coverage include:

- Expanding public programs such as Medicaid or Medicare to cover the uninsured or establishing a new public program,
- Subsidizing the purchase of individual private health insurance through federal or state government funds,
- Taxing hospitals or private health insurance plans to create a pool for paying for care for the uninsured, or
- Requiring employers to provide health insurance coverage for employees and dependents.

The first of these alternatives would require substantial new taxes from corporations or individuals. Given current governmental budgetary problems, public funds might be better targeted on those low-income uninsured falling outside the workforce. In addition since some of the working poor and near-poor have private health insurance coverage through employers, public coverage would displace current private coverage and add considerably to public outlays.

The second approach would also require additional taxes to pay for subsidies of an inherently inefficient type of health insurance coverage. Individual health insurance plans run administrative costs 30 to 50 percent of benefits, compared to 3 to 5 percent for Medicare and Medicaid. Public monies would go further by directly covering the uninsured under Medicaid or Medicare than by indirectly subsidizing coverage under individual private health insurance plans.

The third approach of taxing hospitals or private health insurance plans would shift the financial burden of covering the uninsured onto the insured. Those employers providing coverage for their workers would be doubly burdened--picking up the costs of their own workers plus the cost of workers in firms not providing such coverage. In a given industry, firms providing health insurance coverage for workers would be at a serious competitive disadvantage to those firms not providing such coverage.

In the light of these alternatives, requiring minimum employee health insurance coverage has much to commend it. It would minimize new taxes required to fill the gaps in health insurance coverage. It would build on the current system of employer-provided private group health insurance.

It would spread the cost of expanded coverage more equitably among firms, rather than concentrating the burden on those firms voluntarily electing to provide coverage to their workers.

Economic Cost of a Minimum Employer Health Insurance Plan

There are several cost concepts which need to be considered in evaluating the economic impact of a minimum employer health insurance plan. The incremental cost of coverage to society is the additional health services or expenditures which would result from improved coverage. Simply put, people who now fail to get health care for financial reasons could be expected to receive it. More pregnant women would receive adequate prenatal care; more hypertensives would receive regular attention from a physician.

Other costs are transferred from one party to another. The uninsured would have lower out-of-pocket expenses for health care; these costs would be shifted to their employers. Those individuals purchasing individual private health insurance would have reduced premiums. Those premiums would be paid by their employers.

The ultimate burden of such expenses, however, might be shifted onto others. Employers might elect to lower wages (or raise them less than they otherwise would) if forced to pay for health insurance coverage. In this case, the cost of health care for the sick uninsured would be spread over all uninsured workers in the form of reduced wages rather than concentrated on those uninsured with serious illnesses. Since group insurance is less costly than individual insurance, workers who now purchase individual insurance would have a net reduction in premium cost and out-of-pocket costs.

If the employer were unable to shift the cost onto workers, because of minimum wage provisions, these costs might be shifted onto stockholders in the form of lower profits or consumers in the form of higher prices.

S. 1265 could be expected to have a modest incremental economic cost and result in transfers of costs from individuals and governments to employers. These costs in turn would likely be shifted largely onto workers. Estimates from the Actuarial Research Corporation of S. 1265 appear to be the most reasonable estimates of the premium cost of the mandated plan. These estimates indicate that an individual plan would cost $642 annually; a family plan would cost $1,631; and the per worker cost would average $1,186 in 1988. I have compared these estimates with estimates of employer-mandated coverage I was responsible for in 1980 and find them within the right range given increases in health care expenditures since that time.

Actuarial Research Corporation notes that costs would be lower for workers choosing to obtain care through HMOs as the plan encourages. This, too, is corroborated by other research studies.

Data from the 1985 Consumer Population Survey suggest that 13 million uninsured workers would be newly covered by S. 1265, or a total of 24 million people including family members. In addition 6 million workers who now purchase health insurance coverage individually would be covered under employer-provided group coverage. Applying the per worker rates to these counts of affected workers suggests a total cost of about $23 to $25 billion in 1988.

These costs, however, are largely transferred costs rather than new economic costs. Roughly, it could be expected that $5 billion would displace current governmental outlays (e.g. under Medicaid, VA, and state and local government hospital subsidies). Another $15 billion would displace out-of-pocket payments for health care by uninsured individuals and individual insurance premium payments for those with individual health insurance. The remaining $5 billion would represent new health expenditures for health care which would not currently be received by the uninsured.

These outlays are modest given the current size of the health care sector. In 1986, national health expenditures were $458 billion, of which over $185 billion came from government, $115 billion came from consumers directly out-of-pocket, $145 billion came from private health insurance payments, and the remainder from miscellaneous private sources.

Viewed from this perspective, the proposed bill would add about one percent to total outlays for health care, increase the private share of total health spending from 59 to 60 percent, and reduce the out-of-pocket share of health spending from 28 percent to about 26 percent. These are not revolutionary shifts in health outlays and could be expected to have only modest effects.

From the perspective of the uninsured, however, the plan would provide health insurance coverage for an additional 24 million Americans, remove the financial obstacles to obtaining health care for children, pregnant women, and those with chronic health problems, avoid postponing care for serious health symptoms such as bleeding or loss of consciousness, and lift the crushing financial burden a serious health problem can inflict.

Inflationary pressure from the new expanded pressures can be expected to be minimal. The health sector is currently experiencing serious excess capacity -- both in terms of low hospital occupancy rates and a significant increase in the supply of physicians. New health care services by those who are currently uninsured could be accommodated easily within the current system without generating inflationary pressures.

Minimum Health Coverage and Impact on Employment

In large part additional employer costs could be expected over the longer term to result in lower wages than would otherwise have been paid. The exception to this is those workers at or near the minimum wage where the employer could not legally lower wages. Data Resources Institute estimates that this would result in reduced employment on the order of 100,000 to 120,000 jobs, or add about 0.1 percentage points to the unemployment rate. This is a relatively small change in the context of the creation of 16 million new jobs in the last three years, and would be much smaller than the employment impact of efforts to cut federal budgetary outlays under a deficit reduction effort.

This estimate would appear to be within a plausible range. Currently, 4 million workers with wages less than $4.00 per hour are uninsured. Over 90 percent of these workers work at least 25 hours per work; at least 75 percent work 35 or more hours per week. The employer share of the premium would average about 50 cents per hour for most uninsured workers. Studies suggest that a 15 percent increase in the minimum wage might result in a 1.5 percent reduction in jobs. Applying these to the 4 million workers suggests about a 60,000 loss of jobs. Thus, the 100,000 to 120,000 figure would appear to be an outside estimate.

One important point, however, is that the additional health services received by the uninsured under this plan would in itself have an employment stimulating effect. The $5 billion in new health expenditures could be expected to add at least 100,000 jobs in the health sector. The net employment impact of the bill, therefore, may be positive rather than negative. This should not be surprising since most new "spending" programs are expansionary rather than contractionary, even when financed by additional revenues.

IRET Estimate of Economic Impact

A study by Robbins and Robbins for IRET has estimated that the employer minimum health plan would cost $100 billion and result in a loss of one million jobs. This study contains at least four serious flaws:

- o It overestimates the per worker cost of the S. 1265 benefit package.
- o It erroneously assumes that most employers would be forced to upgrade existing health insurance coverage.
- o It fails to take account of coordination of benefit provisions in private health insurance plans that would avoid duplicate payments for services.
- o It does not consider the employment expansionary impact of providing new health services.

The study assumes that the per worker cost would be over $2,000, resulting in a cost of $37 billion for 17 million newly covered workers. This is far in excess of the Actuarial Research Corporation estimate and can not be reasonably justified.

The IRET estimated cost exceeds the cost of current employer-provided health insurance coverage. In 1988 employers will be expected to spend over $120 billion on health care coverage for 81 million workers. The average per worker cost of health coverage will be over $1,500.

Current employer plans on average are more generous, not less generous, than the minimum plan. The minimum plan requires a family deductible of $500 and a maximum out-of-pocket cost of $3,000. A survey of employer plans by Louis Harris and Associates for Equitable in 1985 found that over half of employer plans had deductibles below $100. A survey of employer plans in 1984 by Hewitt Associates found that 37 percent had no deductible for hospital care and half had a total deductible of less than $100. The minimum plan with its high deductible can be expected to cost considerably less than the typical plan now covering workers.

The IRET cost of new coverage of $37 billion, therefore, is a gross overestimate. In addition, since current employer plans are more generous, not less generous than the minimum plan, there would be no $16 billion cost for upgrading coverage. Employers could add any uncovered benefits such as well-baby care for no additional cost by raising current deductibles.

Finally, the IRET study erroneously assumes that there would be $45 billion in duplicate insurance coverage. Private health insurance plans have quite sophisticated systems for coordinating benefits when a two-earner family is covered by multiple plans. Rules followed by companies specify which plan is primary payer. Beneficiaries do not receive double payment for health care services received. The $45 billion duplicate coverage cost, therefore, is inapplicable.

Numerous other criticisms could be raised about the IRET analysis. Administrative costs of group insurance, for example, are considerably less than individually purchased insurance. The estimated $2 billion incremental administrative cost does not consider these offsets.

Summary

The minimum employer plan would accomplish much for a modest outlay and minimal adverse economic effects. The benefits contained in S. 1265 do not constitute an excessively generous or financially burdensome plan. It is estimated that the plan would cost $23 to $25 billion, or $1,200 per newly covered worker, or on an hourly basis about $0.50 to $0.60 per hour.

The plan is likely to be expansionary rather than contractionary. The direct job loss from higher labor costs is at most 100,000 to 120,000. The additional jobs created in the health sector by expanded demand for services would be at least 100,000. Other factors suggest that any adverse effect on employment would be minimal. The labor market for entry-level workers is tightening with the drop in fertility in the mid-1960s leading to a smaller size cohort entering the labor force. Loss of jobs in such an environment is less likely. The minimum wage has not been increased since 1981, so that the cost of entry-level workers has declined in real terms over the last six years. Finally, the types of jobs that are potentially affected are largely in the service sector or retail trade which are not as sensitive to international competition.

Coverage of employers and dependents under this plan would add 24 million more people to health insurance coverage, and drop the number of uninsured from 37 million to about 13 million. This would provide much needed improvement in access to health care for a largely low-income population. It would help reduce the intolerable delay in obtaining needed health care for pregnant women, children, those with chronic health problems such as hypertension and diabetes, and those with life-threatening symptoms such as bleeding, chest pain, and loss of consciousness which many uninsured now experience.

A balanced assessment suggests that mandating employer coverage for workers and their families would be the least disruptive and fiscally burdensome approach to helping close the gap in health insurance coverage of Americans. It deserves serious consideration. Thank you.

SENATOR HATCH'S QUESTIONS FOR DR. DAVIS

1. DR. DAVIS, YOU INDICATE THAT SOME EMPLOYMENT LOSS COULD OCCUR AS A RESULT OF THIS LEGISLATION. CITING THE FORMULA WHICH HAS BEEN OFTEN MENTIONED IN THE MINIMUM WAGE DEBATE, THAT A 10% INCREASE IN LABOR COSTS WOULD RESULT IN A 1% REDUCTION IN EMPLOYMENT, YOU CALCULATED A POSSIBLE LOSS OF 100,000 TO 120,000 JOBS. WHICH JOBS DO YOU THINK WILL BE MOST AFFECTED BY THIS REDUCED PROPENSITY TO HIRE?

2. DR. DAVIS, I KNOW THAT PERSONAL BUDGET CONSTRAINTS PREVENT MANY INDIVIDUALS FROM OBTAINING A HIGHER LEVEL OF HEALTH COVERAGE, BUT ARE THERE ANY INSTITUTIONAL OR LEGAL BARRIERS THAT PREVENT THIS IMPROVEMENT IN COVERAGE?

RESPONSES TO SENATOR HATCH'S QUESTIONS ON EMPLOYEE MINIMUM HEALTH BENEFITS

BY KAREN DAVIS

1.) My own estimate is that the bill would have no net employment loss. Jobs would be expanded in the health sector, including jobs ranging from minimum wage workers (e.g. changing staff, clerical workers) to higher paid lab technicians. Jobs would be contracted in minimum wage jobs, primarily in smaller firms and in the services and retail trade sectors.

2.) Individual insurance is not available at any price to those the industry regards as "uninsurable", i.e. those with serious health conditions. Increasingly, insurers may refuse coverage to those deemed to be at high risk for AIDS (e.g. single men or drug abuse history). Individual insurance plans frequently protect the insurer not the beneficiary by excluding pre-existing conditions, limiting the dollar amount of covered benefits, etc. Finally, individual insurance plans are prohibitively expensive without the economies of scale inherent in employer-provided group health insurance plans.

The CHAIRMAN. That was an excellent statement. It answered all my questions. We will see if Senator Hatch has any.

Senator HATCH. Yes. I want to know, Dr. Davis, if CBO's figures take into account the cost impact on the rise in premiums for existing insured employees.

Professor DAVIS. As I understand, the total cost estimate of CBO is that there is $27 billion in health spending. Of that, about $5 billion reduces current public spending because it reduces the Medicaid outlays, it reduces outlays of State and local hospitals, maybe even some small savings to Medicare. So of that $27 billion, $5 billion is a transfer away from public spending.

In addition, CBO, I understand, estimates that about $10 billion of that replaces individual insurance premiums and out-of-pocket expenses. My own estimates are a little bit higher than that, but we are within the same ball park.

Then you have, of the remaining $25 to $27 billion, the new spending, which is in the order of $5 to $10 billion. So that is the new health services; that is what gets the uninsured in to the physician, into the hospital, it gets the hypertensives their care. That takes new additional spending to bring up the under-utilization among that group. But that is also what generates the new jobs in the economy to provide those services.

Senator HATCH. You are talking about public employees, though. What about private employees?

Professor DAVIS. I am talking about the total employees.

Senator HATCH. Now, I personally believe that this bill is too much to impose on our society, and I feel strongly there have to be better alternatives to increase access to health care. Could you describe any that you might consider to be viable and less costly options to help the 37 million people who presently need the help?

Professor DAVIS. You are looking for other options of covering the 37 million?

Senator HATCH. Yes, that may be viable and less costly.

Professor Davis. As I see it, there are three other alternatives instead of just requiring the employer to provide the health insurance for the worker. The main approach that we have looked at for a number of years is having the Federal Government take this responsibility on itself.

Senator HATCH. Just increase the burden of the Federal Government.

Professor DAVIS. So you would expand, for example, the Medicaid Program, or you might bring the unemployed into Medicare, or you might set up a whole new program that would cover those who fall between the cracks of employer coverage and public programs that exist today. So public is the way we thought in the past. But that does add to the Federal budget, and it would require new tax sources, and there is nothing wrong with that. But when you do this approach, the minimum approach, you still have about 13 million people out there who will not be covered under employer plans, and those are very poor and near-poor people. So you are probably going to have to use public funds under Medicaid to pick up the poor who do not get helped by this bill. So you might want to save public funds to be targeted on that group.

A second major approach is to use public funds to subsidize the purchase of individual insurance. Now, that could be Federal moneys, it could be State Government moneys. You might set up risk pools at the State level; charge people a premium that they could afford, which would not cover the costs of care, and then use State Government moneys or Federal Government moneys to subsidize it. And you could do that, but again, it is additional public cost.

The other disadvantage of that is that those plans tend to run very high administrative costs. Our experience with individual insurance is that that runs 30 to 50 percent of the premium compared with Medicare, that keeps administrative costs down to about 3 to 5 percent. So that option uses public moneys to buy into an inherently inefficient health care system.

The third approach is one that is being tried in some places, such as Florida and South Carolina, would be to simply enact a tax on hospitals or a tax on all health insurance plans in the State or in the country. And you would put those moneys into a pool and use that to provide charity care to people who cannot otherwise pay.

Now, the difficulty with that is the hospital has to get the money somewhere, and the health insurance company has to get the money somewhere, so they would just raise their rates to people with private insurance, group insurance. So in that option, you get the employers who voluntarily provide health insurance to their workers, paying twice—once for their own workers and then indirectly through this tax on hospitals and health insurance plans that cover the uninsured.

Senator **Hatch**. No matter what way you look at it, somebody is going to have to pay for this; but under this bill, the employees are paying, and paying a great amount.

You assume that the uninsured would have lower out-of-pocket expenses for health care under Senator Kennedy's proposal, since these costs would be shifted to their employees. First of all, wouldn't this be true only for those workers who required health care costing more than their premium share and their deductible—roughly $487 for a single person and $737 for a family—is that true?

Professor **Davis**. There would be transfers within the group of uninsured. Basically what would happen is those uninsured who are very sick today, having multiple hospitalizations, needing health care and having to pay for it out-of-pocket, they would then pay a premium, or 20 percent, of a group health insurance plan. So they would pay less. Those uninsured who are healthy today and absolutely never go to a physician, do not buy private individual health insurance, they are going to have to pay first of all 20 percent of the employer premium—and I think you have a good point that they may also pay some reduced wages over time, because the employer would try to shift that cost back on the worker.

So what you have is a redistribution from the sick uninsured to the health uninsured in part. But anyone who is healthy today can be sick tomorrow, so that is in fact why we buy insurance is to protect ourselves against that eventuality.

Senator **Hatch**. Even if an individual were uninsured and paid for a doctor visit out of his or her pocket, he or she would not particularly benefit from this legislation unless those out-of-pocket costs exceeded $487 per year; is that correct?

Professor DAVIS. It is a minimum health benefits bill, there is no doubt about that. There is a $250 deductible on the individual and $500 on the family. There is better coverage——

Senator HATCH. So, they are paying for everybody else. It is a cost redistribution, then, is what it is.

Professor DAVIS. I do think it is important to point out that there is good coverage for prenatal and pregnancy care in this bill, so that that type of care, the family would be able to obtain without cost.

Senator HATCH. Well, what is the proportion, if you can tell us for our records here today, of the uninsured for whom it is medically necessary to receive medical care in excess of their premium share plus the deductible? Who would fit in that category? What is the proportion?

Professor DAVIS. So you want to know about what proportion of the uninsured have health expenses, say, over this $250 per person deductible who would wind up using that.

Senator HATCH. Plus their premiums, and plus their deductibles.

Professor DAVIS. Plus their premiums. Again it is a very rough estimate, but my guess is we are talking about 60 percent——

Senator HATCH. So you are saying 40 percent of them are really going to pay more for this program.

Professor DAVIS [continuing]. Would not exceed a $500 family deductible. That is a very rough guess.

Senator HATCH. So if you were on a real low fixed income, and you did not have health problems that cost above and beyond the deductible plus the premiums that you paid, you would be pretty upset having to pay all the extra costs of this program, it seems to me.

Professor DAVIS. But you have got this peace of mind of knowing if you get sick you are taken care of. You have got the peace of mind of knowing that your children can get care free-of-charge, your babies. You have got the peace of mind of knowing that a pregnant wife can get adequate care and will not have to put that off.

Senator HATCH. That peace of mind doesn't help if you cannot buy groceries and the other things that are essential. Those are some of the practical things I think you have to look at. I think if people had the choice between having some money and being able to buy groceries today or consumer needs, and they feel they are relatively healthy, I do not think they are going to be worried about the future health care costs quite as much.

S. 1265 puts a mandate on workers to accept the health benefit as well as the employers to offer it. Now, do you believe that such an arbitrary requirement is necessary, given the fact that some people are voluntarily passing up enrollment in health insurance plans, even though their employer is paying a substantial share of the premium cost?

Professor DAVIS. I think that this is definitely something that we have to do in terms of improving access to needed health care services for this population group; that we just cannot continue as a society to have people going without care and suffering the health consequences of that.

Senator HATCH. Let me submit my additional questions to you in writing, if you would answer them for the record.

Professor DAVIS. I would be happy to.

Senator HATCH. And now let me ask Mr. Moore a few questions. Mr. Moore, who will pay for S. 1265?

Mr. MOORE. Well, ultimately, the employee is going to pay most if not all the cost of this, because it will be shifted back to reduced salaries and reduced other benefits that presumably the employee would prefer to the health insurance. They will not have that option. They will have to pay for the insurance themselves.

Senator HATCH. Well, as I look at most of the impact of the cost of S. 1265, or more appropriately, the tax increases inherent in S. 1265, the cost falls predominately on lower-income groups. Am I wrong there?

Mr. MOORE. Lower-income groups will be the group particularly adversely affected. Karen Davis mentioned 100,000 unemployed, mainly teenagers—black teenagers, probably. I think it is going to be higher than that. But the cost will be shifted to them. Many will not be able to get jobs.

Let me tell a little story, if you do not mind, Senator.

Senator HATCH. Go ahead.

Mr. MOORE. It is personal. My daughter came to Washington a little over a year ago, right out of college, and wanted to get a job at a magazine. She searched around, and she got herself an unpaid internship in one of the local magazines. After a while, they liked what she was doing, and they put her on part-time, minimum wage; so she went from zero wage to some wage, but it was only part-time. Now she has moved up to a permanent employee, making a good wage, and with fringe benefits. But she would have never had that opportunity had this bill been in effect, because they would never have put her on part-time. They could not have afforded to put her on part-time; they had to either make her full-time plus all these fringe benefits, or not at all, and they would not have made that step.

So young people would have a more difficult time getting into the labor force and getting started if this bill gets enacted.

Senator HATCH. I see. What do you believe will be the impact of S. 1265 on lower-income groups if we also pass S. 837 legislation, which would raise the minimum wage to $4.65 over a three-year period and then index it thereafter?

Mr. MOORE. It will be devastating to those with the least skill, with the least training, with the least experience. Again, study after study has indicated that this would particularly adversely affect teenagers and especially black teenagers.

One of the things we have seen during this growth in the economy over the last five years is that black teenage unemployment has declined significantly over that period of time. I believe one of the reasons for that is that we have not increased the minimum wage. If we increase the minimum wage, we are going to increase the unemployment, especially of black teenagers.

Senator HATCH. Mr. Moore, what impact do you think this legislation will have on other business expenditures and investments?

Mr. MOORE. Excuse me—what was the question again?

Senator HATCH. What impact do you think this particular legislation will have on other businesses with regard to their expenditures and investments?

Mr. MOORE. Well, initially, this is going to raise the cost of labor to many firms, especially small firms, but many other firms as well, and reduce their investments. Ultimately, as I said earlier, the cost will be shifted back on the employees, but for a while it means somewhat higher prices, less investment and less economic growth until we get the adjustment.

So we are imposing a tax on business by this, and that is going to slow up business.

Senator HATCH. You suggested that large firms may be better off under this legislation than small firms. Could you elaborate on that point?

Mr. MOORE. Yes. Many large firms already meet these standards. They provide health insurance for most of their employees, if not all of their employees. So the cost to them is either zero or negligible. Their competitors, often which are the new start-up firms which are eroding their business, will have to provide more benefits and higher costs to them. So you are disadvantaging the small competitors and advantaging the already well-established big firms.

Senator HATCH. Let me just ask one more question; in her testimony, Dr. Davis stated that she believed this legislation would actually create jobs in the health care industry, offsetting employment losses elsewhere. Now, do you agree with that observation that this bill actually might create more jobs overall?

Mr. MOORE. No, I do not agree. Since employees will have less disposable income, as your figures show, afterwards, they spend more on medical area, but they will have less resources to spend on other areas, so we will have less spending on all the other areas of your disposable income and a loss in jobs that we cannot calculate here or there.

So on net, there is no doubt in my mind that this is a job loser. The exact number, I cannot say, but I would certainly agree with Dr. Davis that it is over 100,000 and maybe substantially more than 100,000.

Senator HATCH. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Quayle?

Senator QUAYLE. Thank you, Mr. Chairman. I am going to use part of my time for an opening statement. Unfortunately, I was unable to be here when you started.

First, on the witnesses—not these two witnesses—but Mr. Chairman, again, we have a problem in obtaining advance copies of the testimony. I know you have said it before, publicly and privately, but today we have got three witnesses—Mr. Gramlich, Mr. Adams and Mr. Trapnell—who have not complied with the rules. Two of them, we did not get until this morning, and one of them, we received last night. It just makes it very difficult for my staff and for me to be able to prepare questions. I bring that to the Chair's attention. This has happened before——

The CHAIRMAN. The Senator's point is well-taken.

Senator QUAYLE. I am particularly concerned about Mr. Gramlich, from the Congressional Budget Office. We had his draft yesterday and the final version today. Mr. Adams testimony was just delivered; and Mr. Trapnell's, we received last night.

It just makes it very, very difficult, and I just hope that—I presume they had letters indicating that we would like to have it 24 hours in advance. I would just bring it to the Chair's attention. I do not know what to do. It just makes it very awkward and difficult for us to be able to proceed in as thorough a way as we would like.

The CHAIRMAN. Well, the point is well-taken. We do have a rule of trying to get the testimony 24 hours before. Most of the witnesses complied with that. It is interesting that, with the exception of Mr. Gramlich and Mr. Moore, all of these witnesses are basically volunteers. We do not pay any of these witnesses. They are all experienced individuals. We are grateful to them for taking the time and sharing their insights. But we do obviously prefer, for preparation, to get their testimony in ahead. We want to emphasize that, as we also emphasize how fortunate we are to have all of them come here today to testify. They are all busy people; they all have other responsibilities. And this is a complicated piece of legislation. They will be questioned closely, so it takes a great deal of preparation.

So I think the point is well-taken, and we will note that and make an extra effort when we invite the witnesses to underline the point the Senator has made.

Senator QUAYLE. The Chairman is absolutely right; it is a very complicated bill, and that is why it does take time. And I understand that volunteers have difficulties in complying from time to time, but I would just bring it to the Chair's attention, and hope that he and his staff will try and work to get the testimony to us.

The CHAIRMAN. Yes.

Senator QUAYLE. Let me take a couple moments to talk about the bill before us. I ask unanimous consent that my entire statement be made a part of the record, Mr. Chairman, at the appropriate time.

The CHAIRMAN. It will be made a part of the record at this point.

[The full text of Senator Quayle's opening statement follows:]

OPENING STATEMENT OF U.S. SENATOR DAN QUAYLE (R-IN)
AT THE SENATE LABOR AND HUMAN RESOURCES COMMITTEE HEARING
ON S. 1265, THE MINIMUM HEALTH BENEFITS FOR ALL WORKERS ACT OF 1987
November 4, 1987

Mr. Chairman, I am pleased that you have scheduled this hearing to discuss the economic impact of your mandated minimum health benefit package. As you know, the disemployment effects and economic impact of the various mandated benefit proposals that have been introduced are of very strong interest to me.

I also commend you for proposing a solution to the problems facing those Americans who do not have health insurance. You have identified an important problem that certainly merits national attention. While I have strong philosophical objections to the approach you have taken, I certainly credit you for proposing a solution.

In the testimony we will hear today, there will no doubt be disagreements over the magnitude of the cost of this legislation. I believe that CBO has come in with a cost of $27 billion and another witness will testify that it will cost $100 billion. I have questions about the accuracy of both of these estimates. However, the conclusion of both of these analyses is the same --- that the economic impact of this legislation will fall disproportionally on those workers and businesses least able to afford it.

Given that employees would not have the choice to opt out of coverage, many low wage workers might be unable to afford to meet their other essential needs. Should the federal government dictate how such workers should spend their earnings? I am also concerned about what will happen to these individuals if health care costs --- and thus their premiums --- continue to rise. They could well be depriving their family of more immediate needs to meet the costs of their health care premiums. This is ironic given that it is these low-income individuals whom the legislation is really directed at helping.

I would like to focus briefly on the combined impact of the two proposals the Chairman has proposed to help low-wage workers --- the increase in the minimum wage and the mandated minimum health benefits package. I have attached a chart to my statement which shows that, as of January 1, 1989, the combined cost to employers of S. 837, the Minimum Wage Restoration Act, and S. 1265, the Minimum Health Benefits for All Workers Act, will range from 44 percent for a full-time minimum wage worker to 62 percent for a half-time minimum wage worker. I would point out that the figures CBO will present today will point out that the Chairman's original estimate for S. 1265 needs to be increased by 10.25% --- thus the impact will be even more severe than demonstrated by my chart.

Clearly, we are all well aware of the growing numbers of Americans who either have no health insurance or are inadequately insured. The legislation before us emphasizes the very difficult policy issues that are raised by efforts to remedy this problem. Despite my many reservations about the Chairman's proposal, I do not believe we can ignore this problem.

However, I do not think --- particulary given our nation's track record in containing health care costs --- that it makes any sense to implement a nation wide program without a better estimate of its potential for success. Therefore, I plan to introduce legislation that would authorize a series of pilot projects designed to deal with the problems of the uninsured. While I have strong objections to the mandated employer approach the Chairman advocates, I think it may be appropriate to authorize it as one of a number of pilot projects. Other pilot projects I am considering would include:

* waiving state mandated benefit laws in order to permit the development of an affordable small business health insurance package;

* permitting states to completely restructure their Medicaid Program to integrate employer and employee participation for low-wage workers;

* giving certain employers a choice of providing catastrophic coverage or contributing to a state pool financed through an increase in the unemployment contribution rate.

I realize that many will criticize this approach on the grounds that the problem demands an immediate solution. However, I would suggest to these critics that there is an instructive analogy in our history of welfare reform efforts. In the early 1970s, Senator Long and others argued that prior to implementing whole-scale welfare reform, the Federal government should initiate a series of state pilot projects in order to obtain some sound data on what approaches were and were not successful. I think that we all know too well that the Congress did not take his advice. We did not adopt the pilot project approach until the early 1980s and it is these activities that have furnished the basis for our current efforts to reform welfare.

A look at our past history in dealing with the uninsured population is also instructive. Congress has always focused on broad national solutions to the problem. The subject has been on the table for years. Debate began with the proposals for national health insurance that our Chairman advanced in the early 1970s, followed by the proposals put forth by the Nixon and Carter Administrations. None have ever come close to becoming law. I would suggest that the reason for this failure is lack of confidence in the outcome of any of these approaches. I would urge the members of this Committee to work seriously on the pilot project approach. I think this is the only realistic way we can move forward on this issue and not find ourselves debating this important problem in future years and, again, coming to no resolution.

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Senator **Quayle**. I have said all along throughout these hearings that we cannot just simply ignore the problem that is out there. I think we have a problem with how we are going to work in an expeditious way to try and facilitate the coverage of people who do not have health insurance, who need to have health insurance.

I think the Chairman has come forward with a proposal that is a very comprehensive, macro type of proposal. I do not believe that we are prepared to enact it into law; as a matter of fact, I am considering introducing legislation to try to look at this approach on a pilot project basis. We ought to see how it would work before we jump into it nationwide. We really ought to look at how it works.

I think from past experience, before we go headlong into many programs, that the Congress in fact does learn a lot by some of the pilot projects. This is the direction I want to go in.

Other pilot projects that I will be considering for inclusion in my bill would be, for example, prempting State-mandated benefit laws in order to permit the development of affordable small business health insurance packages. Right now, particularly in small businesses, the question is, how can they provide affordable health insurance packages, particularly given all of the State-mandated benefits?

Also, I would like to see the possibility of permitting States to completely restructure their Medicaid programs to integrate employer and employee participation for low-wage workers.

And finally, one of the pilot projects I am considing would give certain employers a choice of providing catastrophic coverage or contributing to a State pool financed through an increase in the Federal unemployment contribution rate.

These are ideas that I am considering that will be forthcoming in legislation that I will introduce shortly.

I guess, Dr. Davis, my first question would be directed to you. Your testimony relies on the DRI model, concludes that the disemployment effect of this legislation is very minimal. Have you used the DRI model to combine the increase in minimum wage with S. 1265 to see what the disemployment effect would be?

Professor **Davis**. This particular study, which I am happy to share with the Committee, does not look at combining any proposed increase. It could be done——

Senator **Quayle**. Could you do that for us?

Professor **Davis**. It could be done.

Senator **Quayle**. I would like for you, if you would, to submit that to us.

Professor **Davis**. Surely.

[Responses of Professor Davis to questions submitted by Senator Quayle follow:]

QUESTIONS TO DR. KAREN DAVIS FROM SENATOR DAN QUAYLE

In addition to S. 1265, the Chairman has proposed increasing the minimum wage. I am interested in your analysis of the employment impact that increases in the minimum wage will have in combination with increases in mandated health costs for employers. In particular, please estimate the impact of such combined increases on minorities and youth.

While S. 1265 mandates that employees accept the coverage and pay for their share of the premium, it does not provide a mechanism to ensure that this is done. It is my understanding that most state wage laws prohibit involuntary withholding of wages other than for taxes and certain other statutory exceptions. How would you recommend that the employee contribution and mandate to accept insurance be enforced?

Given that the bill currently provides no mechanism to enforce employee participation, how many low-wage workers who will be impacted by this bill do you estimate will participate?

The introduction of Medicare and Medicaid increased the demand for health services in the late 1960s and 1970s far in excess of the capacity of the health services sector to meet the growing demand. Thus, rapid increases in health care costs followed and continue until today --- by the twentieth anniversary of the Medicare Program, the cost of the program was eight times its original projections. What will be the impact of this bill on the demand for health services if such historical trends are followed?

RESPONSES TO SENATOR QUAYLE'S QUESTIONS ON MINIMUM HEALTH BENEFITS

BY KAREN DAVIS

1.) As I indicated, my own estimate is that the minimum health benefits bill would have no net loss in jobs. On balance, it is likely to be expansionary rather than contractionary. The Wharton model predicts that the minimum wage increase would result in about a 100,000 loss in jobs. This strikes me as a reasonable estimate and is extremely minor in the context of our economy with more the 100 million jobs.

2.) If mandatory coverage of employers is desired, the legislation would need to provide for involuntary withholding.

3.) Currently there are 700,000 low-wage workers in firms that do not provide health insurance to workers.

4.) The health sector currently has considerable excess capacity including low hospital occupancy rates and an expanding supply of physicians. Thus, the classic case of inflationary pressure does not apply. In addition, the bill encourages the use of lower cost HMO and PPO plans.

Senator QUAYLE. That is one of the concerns that I have—and I want to ask the witnesses to comment—as we look at the proposed legislation, we are not looking just at minimum health benefits; we are also looking at increase in minimum wage. And if you take those two together, we have put together a chart here where you just take a person on minimum wage, that the increase to the employer, full-time person, would be 44 percent. For a part-time worker, working 1,000 hours annually, the increase would be 62 percent. And also, I think the testimony will show that these numbers may be a little bit low, but they are ball park figures.

I wonder if you look at those numbers, roughly, seeing a 62 percent increase for a part-time minimum wage worker, what kind of an impact it would have on the employer and potentially the economy? Do you have any comments on that general approach?

Professor DAVIS. I see what you are doing there in terms of looking at the increase in the minimum wage. On the health coverage per hour, I am not quite sure whether you have there the total cost or the employer's share. But in any event——

Senator QUAYLE. The employer's.

Professor DAVIS [continuing]. I think what we have to bear in mind is how many workers are we talking about in each of these. The vast bulk of the workers would not be in these examples that are shown here. You are talking about only about 700,000 part-time low-wage workers out of a work force of over 100 million people. So I think you need to bear in mind this is not a typical example; it may be an extreme example, but it is not your typical example.

Senator QUAYLE. You only have 700,000 part-time workers at the minimum wage?

Professor DAVIS. Yes, roughly—who are uninsured and affected by the bill.

Senator QUAYLE. And also who do not have health insurance.

Professor DAVIS. That is right.

Senator QUAYLE. So you are talking about 700,000 there. Now, the full-time minimum wage would be a different number.

Professor DAVIS. I am sorry. That is the combined effect; part-time, full-time, who are uninsured, affected by the bill, at $3.50 per hour or below, and part-time.

Senator QUAYLE. But there would be an impact, wouldn't there, if you raised the cost of hiring an additional part-time person, 62 percent?

Professor DAVIS. I would go along with the DRI estimate that in fact you do get some loss of employment from those types of workers; you are talking about at most, 100,000 workers.

Senator QUAYLE. I guess we will have to put through the DRI computer both of the proposals——

Professor DAVIS. The increase in the minimum wage as well. But I keep stressing the point that this is basically an expansionary bill. If you were thinking of this as a Government program, requiring this type of health insurance coverage, imposing this type of a per-worker tax on employers to finance the bill, you would look at it as a Government spending program which is generating jobs, because you have got to provide these services to people with people.

Senator **Quayle**. Which categories of businesses are mostly affected by this bill? I mean, big business is not going to be affected by this.

Professor **Davis**. That is right.

Senator **Quayle**. I mean, we are basically talking about small and medium-size businesses, aren't we?

Professor **Davis**. Right. A lot of these workers are in firms of fewer than 25 employees. They also are concentrated in certain sectors of the economy—retail trade, the service sector, construction.

Senator **Quayle**. Well, you could basically say that large businesses—and we had several big business chief executives testify in favor of this bill, their companies are not really affected by it. Most of them have coverage—so I think it would probably be fair to say, wouldn't it, that most of the businesses that would be impacted by this would be the small and medium-size businesses. That is a fair assumption, isn't it?

Professor **Davis**. That is right. There are still some firms up there with over 1,000 employees.

Senator **Quayle**. Yes, but not very many.

Professor **Davis**. But not as many?

Senator **Quayle**. Yes. So basically, the impact would be on the small and medium businesses. That is who would be affected.

Professor **Davis**. Right.

Senator **Quayle**. Mr. Chairman, I have a couple other questions, but I see Senator Thurmond has arrived, so I will submit them for the record—unless Mr. Moore might want to just comment on the one question I have raised on the combined impact of the minimum wage and the minimum health benefits, the impact it would have on medium and small businesses.

Mr. **Moore**. Well, we have not done an estimate of the quantitative effect, but I——

Senator **Quayle**. Could you do one for us?

Mr. **Moore**. We could try to look at that, yes, certainly.

Senator **Quayle**. All right. I would appreciate that. We will get the DRI one, and if you could submit one, I would certainly appreciate that.

Mr. **Moore**. We can certainly do that.

The **Chairman**. Dr. Davis, on this point, I understand the CBO says that 25 percent of the working uninsured work for firms with 1,000 employees or more.

Professor **Davis**. That is right, that is right. I am fumbling for that, but that is right.

The **Chairman**. There was just one other fact. As I understand the point, when you were questioned about the number of American families in earlier questioning who would actually exceed the deductible, the figure that we have from HHS is that about 2 million families covered by the bill now pay $3,000 or more in terms of their out-of-pocket expenses.

Professor **Davis**. That is right. There are a number of these, even with very modest incomes, that are faced with these very substantial bills.

The **Chairman**. Senator Thurmond?

Senator **Thurmond**. Thank you, Mr. Chairman.

Mr. Chairman, I have expressed my reservations about this legislation during a previous hearing on June 24, 1987. I will not reiterate these concerns at this time. However, I will make this point. Congress is considering a number of measures that small business is justifiably worried about: High-Risk Occupational Disease Notification; minimum wage increases; mandated parental leave benefits, and mandated health benefits. These measures will add significantly to the labor cost of business, especially small business.

Mr. Chairman, the small business sector of the United States economy has accounted for most of the job growth in recent years, creating 60 percent—I repeat, 60 percent—of the 17 million new jobs. Before acting, I urge the Committee to give careful consideration to the adverse impact on jobs these measures could have.

Mr. Chairman, I have another meeting, but I would like to ask just a couple of questions, and then I will have to go.

Mr. Moore, do mandated benefits increase total benefits to workers?

Mr. MOORE. Pardon me?

Senator THURMOND. Do mandated benefits increase the total benefits to workers?

Mr. MOORE. The total benefits, including the wage package, will actually go down because the employer and employee now essentially negotiate on what is the best wage package they prefer. Some workers would prefer to have more wages and fewer benefits, or somewhat more benefits. By mandating a particular benefit, you do not improve the well-being of workers. This cost will be borne by workers, and you reduce the flexibility of the economy, and some workers will be unemployed.

So in total, the benefits of the employees will go down.

Senator THURMOND. If you mandate a certain benefit, then it is possible that might reduce other benefits that could be provided, is that not true?

Mr. MOORE. It will reduce other benefits, or wages, or both.

Senator THURMOND. Now, Mr. Moore, if mandated benefit measures pass, will we find business shifting to more capital-intensive means of production, causing loss of jobs?

Mr. MOORE. Yes, Senator. It increases the cost of labor; business will respond by investing in labor-saving devices and more automation, which will displace workers.

Senator THURMOND. Mr. Chairman, those are all the questions I have at this time.

I want to thank Mr. Moore and Dr. Davis for their testimony.

The CHAIRMAN. As you know, Mr. Moore, we have certain mandated benefits now. We have Social Security, we have got Medicare, we have got unemployment compensation insurance, we have got child labor laws. Which of those would you like to see repealed?

Mr. MOORE. Senator, the Administration is simply opposed to extending further regulation in this area. I do not know whether you remember, but when you and I last met, we were discussing trucking regulation and its harm to the economy——

The CHAIRMAN. I am glad to get onto trucking deregulation, and I am for getting the Government out in areas of economic regulations. That is not my question. You talked about mandated programs. I have just named some. And if you are not opposed to any of them, you can just say "None. I support all of those" or "I like 'X' out of those." Can you just give me a straight answer?

Mr. MOORE. We support all of those.

The CHAIRMAN. All of those mandated programs.

Mr. MOORE. All the existing ones.

The CHAIRMAN. All the existing mandated programs; none of the existing mandated programs you oppose, is that correct?

Mr. MOORE. That is correct.

The CHAIRMAN. I have no further questions.

I want to thank you very much.

Senator HATCH. Mr. Chairman.

The CHAIRMAN. Yes?

Senator HATCH. Mr. Chairman, I would ask unanimous consent that we allow the following organizations to submit testimony for this hearing: The National Association of Manufacturers, the Chamber of Commerce, the National Restaurant Association, the National Association of Wholesalers, C.A.R.E. Alliance for Responsible Employers, the Marriott Corporation, Small Business Legislative Council, the National Federation of Independent Businesses, the Bell South Corporation, the Associated Builders and Contractors, the Department of Health and Human Services, the American Subcontractors Association, Inc., the Whirlpool Corporation, the American Retail Federation, and the Machinery Dealers National Association.

The CHAIRMAN. Fine. Any group who want to file written statements, we will make a part of the record.

Senator HATCH. Thank you, Mr. Chairman.

The CHAIRMAN. OK. Thank you both very much.

Professor DAVIS. Thank you, Mr. Chairman.

Senator HATCH. Mr. Chairman, I ask unanimous consent that we include written questions to the witnesses.

The CHAIRMAN. Yes. We will leave the record open for submission of questions.

Senator HATCH. Thank you.

[Responses of Mr. Moore to questions submitted by Senators Hatch and Quayle follow:]

Council of Economic Advisers' Response to Senator Hatch's Questions, Following Thomas G. Moore's Testimony on November 4, 1987 on S. 1265, Mandated Health Benefits

1. Most of the impact of the cost of S. 1265, or more appropriately the tax increase inherent in S. 1265, falls on the lower income groups. Dr. Moore, what would be the employment impact of this proposal on those groups, especially minority youth?

Estimates of the disemployment effects of mandated health benefits are necessarily imprecise. Everyone agrees, however, that economically damaging disemployment effects would occur, and that their greatest harm would fall most heavily on groups who are already at a relative disadvantage in the labor market, particularly minority youth. A disproportionate impact falls on black teenagers, because they are young and inexperienced, and earning relatively low wages. Since the earnings of such groups are frequently at or close to the minimum wage, they cannot absorb through lower wages the costs of an effective tax increase such as that imposed by S. 1265. Such groups are therefore most vulnerable to the disemployment effects of legislation that would mandate employment benefits.

Estimates of reduced employment based on the Data Resources Institute model are on the order of about 100,000 to 120,000 jobs. Karen Davis estimates that about 60,000 jobs would be lost. The Congressional Budget Office (CBO) analysis presented before the Committee indicates that substantial cost increases would result in the hourly wages of the lowest-wage workers, but the analysis stops short of making an actual disemployment estimate. The CBO analysis shows very clearly that the percentage increase in employers' cost per hour under S. 1265 is disproportionately high for low-wage workers and notes that there are approximately 6 million workers who now earn under $4.00 per hour who would be adversely affected.

The Committee estimates that its mandated benefits proposal will cost employers about $0.50 per hour per employee. The CBO estimates the hourly cost to be higher, about $0.65 per hour. Higher estimates of hourly costs have also been made. For part-time workers, working 20 hours a week, the effective cost increase per hour would be double that for a 40 hour a week worker, for an hourly cost increase of $1.00 to $1.30. Using the Committee estimates, and assuming for simplicity's sake a $9 an hour average wage, a $1.50 per hour increase for full time workers means about a 5.5 percent increase in the hourly cost of labor. For those earning $4 an hour the employer will be faced with a required 12.5 percent increase. Obviously, hours of work would have to be adjusted in response to this legislation, regardless of the efficiency considerations or preferences of workers that have determined hours of work in the past.

We do not have data that allow precise calculations to be made of the effects of this legislation including likely effects of waivers due to duplicate coverage and possible future increases in health insurance costs. However, many economists have concluded, from the vast number of studies that have been made of the effects of the minimum wage, that a 10 percent increase in the minimum wage reduces employment of teenagers by about 1 to 3 percent. This consensus estimate of effects, together with the Committee's and the CBO's estimate of costs, yields an estimated range of disemployment, from 100,000 to 400,000 jobs lost.

2. Dr. Moore, what do you believe will be the impact of S. 1265 on lower income groups if we also pass S. 837, legislation which would raise the minimum wage to $4.65 over a three year period and then index it thereafter?

The combined effects of mandated health insurance, increased minimum wages, and possibly other workplace mandates that have recently been proposed, would be to reduce employment opportunities, wages, market flexibility, competitiveness, and economic growth. Adverse effects would fall particularly severely on low income groups, on youth, on minorities, on those who are just beginning their working lives and will find their opportunities restricted for needed work experience and on-the-job training.

I believe that the combined effects of such legislation would not simply be additive, but that each would magnify the others, since many employers would face sharp and very immediate increases in their labor costs. Such sudden and severe cost increases would not allow gradual adjustments in work hours and work processes, but would demand changes to be made over a short period of time. An increase in the minimum wage, from $3.35 to $4.65, comes to 39 percent. Adding $0.50 to $0.65 per hour for health benefits comes to a total increase of 54 to 58 percent. Employers would substitute capital for labor and they would substitute higher-wage, higher-skill workers, for lower-productivity, low-skilled workers. Some firms would fail, business start-ups would be reduced, and many industries and areas would be very severely harmed.

The Department of Labor estimates that the minimum wage proposal would result in the loss of between 400,000 to 800,000 job opportunities. Simply adding to these jobs lost our estimates for disemployment due to mandated health benefits comes to 500,000 to 1,200,000 jobs lost.

A major achievement of this record-breaking peacetime expansion of the past 5 years has been gains in the labor market. Fourteen million more Americans have jobs now than in November 1982, with strong employment gains widespread across industries and demographic groups. The unemployment rate has declined by almost 5 percentage points since November 1982, and even larger reductions in unemployment rates have been recorded for blacks, Hispanics, and teenagers. Employment of black teenagers has increased by 50 percent, and the unemployment rate of black teenagers has fallen by more than 30 percent, or 15.5 percentage points. These improvements occurred in large part because the minimum wage did not increase, and because no costly new labor market rigidities were introduced. In contrast, black teenagers made relatively little progress during the expansion of 1975 to 1980. During that period, the minimum wage was increased substantially in nominal terms. Black teenage employment increased by just over 10 percent, and the black teen unemployment rate fell by slightly less than 3 percentage points.

3. Dr. Moore, what impact do you think this legislation will have on other business expenditures and investments?

In the very short run, this legislation will have the effect of increasing other business expenditures and investments, because firms will tend to substitute capital for low-wage workers, whose hourly costs are sharply increased. Over the longer run, however, investment and economic activity will decline. Over the next few years, until costs are passed back to workers in the form of lower wages and benefits, the international competitiveness of our firms will be reduced. Prices of goods produced in the United States will be increased, harming consumers. The economy will be deprived of the potential productive contribution of workers who are made jobless, and the demand for consumer products on the part of these workers, who otherwise would have been employed, will be reduced.

4. You suggested that large firms may be better off under this legislation. Would you elaborate on that point?

Many studies of the effects of market regulation have found that although the overall economic effects of such regulations are negative, certain firms do benefit. Regulations, such as mandated health benefits, are not uniform in their impact across firms.

As you have heard from a number of witnesses, the effects of this legislation would be particularly costly and harmful for small firms. Thus, the larger firms who stand to gain from the reduced competition that smaller firms would otherwise present will stand to benefit. Based on my experience over the years in evaluating the effects of government regulation, I did not find it surprising that certain large private firms have lent strong support to this legislation. Firms that already provide health benefits will stand to gain from curtailing competition from firms that do not, or that offer an alternative menu of employment benefits.

I similarly do not find it surprising that certain firms have supported occupational risk notification, mandated leave, and other forms of labor market regulation. The political process generates self-serving behavior, the nature of which is not always readily distinguishable from altruistic behavior.

The uneven effects of regulation extend well beyond firm size. Some industries will be more affected than others by this legislation, and some regions and states will be more affected than others. It is possible that less affected areas will gain a competitive advantage over more affected areas. Bureau of Labor Statistics tabulations show, for example, that minimum wage workers as a percent of all hourly wage earners are not evenly distributed geographically. The lowest incidence of work at the minimum wage occurs in the New England States, where it is 4.2 percent, and the highest incidence occurs in the East South Central States, 13.3 percent. Thus, disemployment effects will be relatively greater in East South Central States, and relatively less in New England States. Service producing industries such as wholesale and retail trade will be most adversely affected, since these industries employ many minimum-wage workers.

5. You state that employees are likely to pay the increased costs of these health insurance premiums over the long-run. Would you explain why you believe this will be the case and how all the costs are passed on to workers?

If firms absorbed the additional costs, their profits would fall by the amount of the added health insurance premiums they would have to pay to meet the requirements of the legislation. Their alternative is to raise the prices of their products or reduce the compensation of their employees, by slowing wage or benefit increases that otherwise would have occurred. To the extent that firms' profits fall, either directly or due to loss of sales following price increases, they are made worse off. The best solution for firms is to pass back the cost of the tax to workers, either in reduced wages or in reduced benefits of other types. But workers who are paid the minimum cannot absorb reductions; thus the adjustment for such workers is disemployment.

Studies of tax incidence are largely based on the effects of the Social Security payroll tax. Although the results of these studies are mixed, they generally show that most of the employers' costs are eventually paid by workers through lower wages and by consumers through higher prices. Employers may absorb some costs initially, but shifts occur thereafter.

6. In your estimate, what sectors of the economy or types of employers would most likely pass on the full amount of the cost or inherent tax increase found in S. 1265 to employees or to the general public?

This is a difficult question, because we have little data on tax incidence that is of a sector-specific or industry-specific nature. Firms that produce products that compete with imports would find it relatively more difficult to pass on price increases to consumers. Smaller firms, that face more competition in both product markets and in labor markets, might be more likely to be forced to absorb the costs, thus their profits would be most likely to fall, and they would be more likely to fail as a result.

7. Dr. Moore, in her testimony, Dr. Davis stated that she believed this legislation would actually create jobs in the health care industry, offsetting employment losses elsewhere. Do you agree with her observation?

I do agree that the health care industry would expand as a result of this legislation. And some of the resulting expansion would be highly undesirable. It would flow from the cost explosion that results from imposing rigid rules on health insurance contracts, rules that specify deductibles and coinsurance, and that preclude the kinds of successful cost containment measures that we have seen in recent years. Innovations and creative approaches in health insurance contracts would be stifled with this legislation, leading to cost increases that are not matched by benefits either in the provision of superior health care or better resulting levels of health.

Although Dr. Davis is correct that employment in health care services would increase, according to her own statement such increases would not be sufficient to offset employment losses elsewhere. Dr. Davis estimates that some 60,000 jobs might be lost overall due to this legislation; thus employment increases among health workers would occur as even larger employment decreases occur in other industries. My estimates are that overall, some 100,000 to 400,000 jobs would be lost as a result of this legislation.

Response to Senator Quayle's question.

Mr. Moore might want to just comment on the one question I have raised on the increase, looking at the minimum wage and the minimum health benefits, the impact it would have on medium and small businesses?

As I indicated in my answer to Senator Hatch's question, a combined estimate of jobs lost due to both increasing the minimum wage and mandating health benefits is about 500,000 to 1,200,000 jobs. Since the working uninsured are concentrated in small and medium size firms, the greatest adverse impact would occur among these firms, rather than among larger firms, which more commonly provide health benefits.

The **Chairman**. Our next witness is Dr. Edward Gramlich, the Acting Director of the Congressional Budget Office. With him is Steve Long, who has been the lead investigator on this bill.

Before Dr. Gramlich begins, I would like to thank him and Steve and the other analysts at CBO for the fine work they have done in developing the analysis we need to produce and refine this legislation. The information they gave us may not always have been what we expected, but we knew we could always have confidence in it.

We are delighted to welcome you.

STATEMENT OF DR. EDWARD M. GRAMLICH, ACTING DIRECTOR, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC, ACCOMPANIED BY STEVE LONG AND JACK ROGERS, ANALYSTS

Dr. **Gramlich**. Thank you, Mr. Chairman.

I am pleased to have this opportunity to testify before the Committee to comment on the bill.

Before I get into the testimony, let me comment on the procedural points that were raised earlier.

First off, I have to my right, Steve Long and Jack Rogers, who have done the careful work on the bill; and as you know, both of you, it is a very complicated bill indeed, and they have worked very long hours for a long time.

We have tried hard to service both the Majority and Minority staffs on the bill. And as both of you know, we did brief your staffs on Monday afternoon, separately, on the details of the bill.

The testimony was sent over here 24 hours ago. It did say "Draft" on it. But as both of you again know, your staff was told that the substance did not change and the numbers did not change. We did make a few editorial changes in that, but for all intents and purposes, you have indeed had the testimony for 24 hours.

We have tried as hard as we could, and our staff has worked very hard, to provide this information in time——

Senator **Quayle**. I understand it is exceedingly complicated, and I fully appreciate the work you are doing. The only thing is that the draft had many of the numbers left out. So the conclusions, we did not get that until this morning.

Dr. **Gramlich**. I was told that all of the numbers, you have had for 24 hours.

Senator **Quayle**. No, that is not the case. We did not get that until this morning. Did you submit it to the Committee—when did you give it to the Committee? Maybe you gave it to the Committee and we just did not get it?

Dr. **Gramlich**. Well, maybe we ought to talk about this later, but I believe that you did have them, but we will adjudicate this.

Senator **Quayle**. Somewhere in the chain of command, it did not——

The **Chairman**. Well, I think the point has been made. I think one of the advantages—I do not know how often they do it—the CBO comes up and briefs the staff, which they did, as I understand, yesterday morning. I think that that is an excellent process and procedure. I think the point has been made.

But we are grateful to you for your work.

Dr. **Gramlich**. Well, thank you.

I would like to submit my statement, which is about 15 pages, for the record. It is too long to read, and I will not do that. The statement covers three points, and I would like to talk about each very briefly, just in the manner of a numerical referee here. We are not for or against this bill; we are just trying to do the numbers here.

The first point is the magnitude of the problem and the response of S. 1265. The second point is the direct impact of the bill on individuals and firms. And the third point are the economic and budgetary impacts.

You can follow along by just referring to the main pictures and tables in the statement. The first one involves the problem and the response of S. 1265, is the picture on page 3 of the testimony. It is after page 2. It is not actually labelled as page 3; it is after 2 and before 4. And the top panel there shows that the number of uninsured persons is large and has been growing rapidly over the decade.

The top panel shows the non-elderly population sources of health insurance, if any, in 1987. Currently, about 67 percent of this population is covered through employment-based sources, 8 percent by Medicaid and Medicare, and 7 percent by some other source such as individual policies.

But the question under investigation this morning is that nearly 18 percent, 37 million people, have no health insurance at all, and this is up from 15 percent, or 30 million people, in 1980; and as the bottom panel shows, that represents a growth of 25 percent, which is a large growth in this period when employment has expanded.

Moving right along, let me now talk about the direct effect of the plan on individuals and employers, and now we will refer to Table 1 on page 6. This table shows that S. 1265 would require insurance for 51 million people, including 23 million, or nearly two-thirds of the previous 37 million, of those who were previously uncovered; in essence, only individuals and families where no one was employed at least 17½ hours a week would continue to be without health insurance.

The bottom two rows there, about 29 million people, the 16 and 13 numbers over in the lower right-hand corner, of the 51 million people who would acquire new health insurance are already insured to some extent. Of the 16 million, about 9 million of them are covered by individual policies. Because these policies tend to be relatively expensive, and their benefits would generally overlap with those from the new employment-based group insurance, many of the individual policies would probably be dropped by their owners.

Since these people would pay at most 20 percent of the new plan's premiums, the direct effect would be to improve their coverage and lower their costs.

In contrast, 3 million people affected by MHB who currently participate in Medicaid would almost certainly continue to do so, because Medicaid's provisions are more generous than those of most employment-based plans, and participation is essentially free. Thus, the members of this group would seldom find their health coverage improved. Moreover, the roughly 40 percent of them who earn $4.20 an hour or more might have to pay the employees' share of the new plan's premiums, reducing the resources they would have available for other purposes.

Finally—and this is the subject of a lot of dispute this morning—for 13 million workers, the new coverage from their own employer would overlap with benefits provided through another family member's employment-based plans. Employees would have to participate in their own employers' plans. Whether they would continue to participate as dependents in the other plans would depend on whether the additional coverage would be worth the additional premiums they would have to pay, if any.

Referring to Table 2, page 8, the Act would also require that $27 billion in incremental health insurance costs be paid through employment-based plans. These premiums would initially be paid primarily by employers. The bulk of employers would, however, either be unaffected by MHB because they already offer health insurance plans that would satisfy the Actuarial Equivalency Test, or they would just have to add the bottom row there, the prenatal and well-baby benefits, for an aggregate cost of about $2 billion.

In sharp contrast, employers that would be required to purchase new policies for their workers or dependents would incur direct costs of about $22 billion or $900 per employee. Because this amount would represent a 12 percent increase in these employees' wages, the affected employers might have some difficulty in adjusting in the short run.

That brings me to the third point which I will talk about, which is the economic effects of this bill, and for that, I want to refer to Figure 2 on page 12, and just the bottom panel of that figure.

The immediate effect of the MHB would be to raise employers' costs for health insurance if they did not already offer plans that met the Act's requirements, or if their employees were not enrolling themselves or their spouses and dependents. If the affected employers did nothing in response, their profits would fall by the amount of additional contributions. Alternatively, over time, they may raise prices of their products or reduce the employees' compensation compared with the levels they would otherwise have attained.

Now, the exact division among these alternatives is not known. Employers would certainly have to strive to minimize the impact on profits. Because rising prices would reduce sales of their products, affected employers would probably adopt this strategy only to the extent that they could not shift costs to employees. This shift could be accomplished by limiting wage increases, reducing fringe benefits of other types than health insurance, or by cutting the quantity of labor employed. Because most of the workers who would be affected receive little or no compensation in the form of fringe benefits, the long run effect would be to lower wages by about the amount of the employers' required contributions.

That brings in this bottom panel of Figure 2, which shows what the direct effect of the premium would do to the wage costs at each level of wage there. As you see, it declines as the wage rises, because the cost is essentially the same but the denominator is increasing. So that would be a good proxy for where one might look for disemployment effects. That is, there would be a fairly sharp increase in direct costs for people right around the minimum wage, but tapering off as the wage got higher.

The previous estimates on employment loss, we have done some back-of-the-envelope calculations, and my own feeling is that the 100,000 workers would probably be slightly high, but we would be happy to look at that more carefully.

Finally, let me refer to Table 4 on page 15, which gives the budget impact. You see the numbers there. There are savings in outlays for the public health plans, Medicare and Medicaid, and for the defense health plan; but then there is a revenue loss which essentially involves the fact that this would be a higher cost to the employers, and if there were a shift in wages, lost wages, then there would be a revenue loss implicit in that, which we have calculated out there.

One question on that is could the shift come out of profits, and if so, would the budget calculations differ; and the answer is they would not differ very much because you would still get a revenue loss, and this time it would be a loss of corporate profits.

So that as far as we can tell, though the numbers are large, the budget impact of this bill seems to be rather modest.

That concludes the abridged summary of the statement, Mr. Chairman, and I would be pleased to take your questions. Apparently, I have driven Senator Quayle away.

[The prepared statement of Dr. Gramlich follows:]

Statement of
Edward M. Gramlich
Acting Director
Congressional Budget Office

before the
Committee on Labor and Human Resources
United States Senate

November 4, 1987

One of every six Americans under age 65 — or 37 million people — has no health insurance and, consequently, receives only about two-thirds as much health care as the rest of the population. This circumstance, which may lead to deteriorating health over the long run, is especially notable for the 12 million uninsured children who do not choose their insurance status for themselves. Moreover, part of the cost of care that the uninsured receive is shifted to others. The insured and their employers, for instance, pay higher hospital charges that cover bad debts and charity care. Ultimately, taxpayers pay other costs — through subsidies to public hospitals, for example.

Numerous proposals have been set forth to address the problem of the uninsured, reflecting the diversity of reasons why different groups lack coverage. One option — S. 1265, known as the Minimum Health Benefits for All Workers Act of 1987 — would require that employers provide health insurance for their employees and pay most of its cost. This statement addresses three topics:

- The magnitude of the problem and S. 1265's response;
- The bill's direct impacts on individuals and firms; and
- Its indirect effects on labor markets and governments' budgets.

THE PROBLEM AND S. 1265'S RESPONSE

The number of uninsured is large, and it has been growing rapidly over this decade. The top panel of Figure 1 shows the nonelderly population's sources of health insurance, if any, in 1987. 1/ Currently, about 67 percent of this population is covered through employment-based sources, 8 percent by Medicaid or Medicare, and 7 percent by some other source such as individual policies. Nearly 18 percent, or 37 million people, have no health insurance -- up from 15 percent, or 30 million people, in 1980.

The bottom panel of Figure 1 shows the percentage change in the number covered by each insurance source since 1980. Because the total nonelderly population grew by 6 percent, but employment-based insurance grew at only half that rate, the proportion of the population covered by this source dropped. Moreover, the number covered by other, largely private, insurance actually declined by 10 percent. On the other hand, Medicaid and Medicare covered 17 percent more people in 1987 than in 1980. The net effect of all these changes was a 25 percent growth in the number of uninsured.

This increase contradicts the common expectation that, as the economy recovered from the 1981-1982 recession and employment expanded, the number of uninsured would drop. One contributing factor is that, although the proportion of workers with employment-based health

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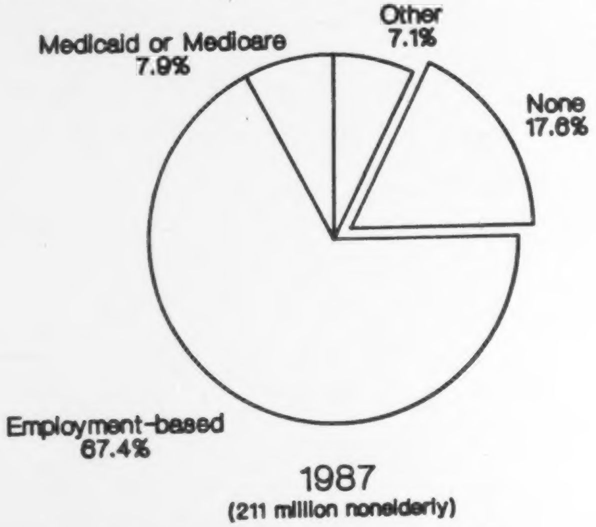
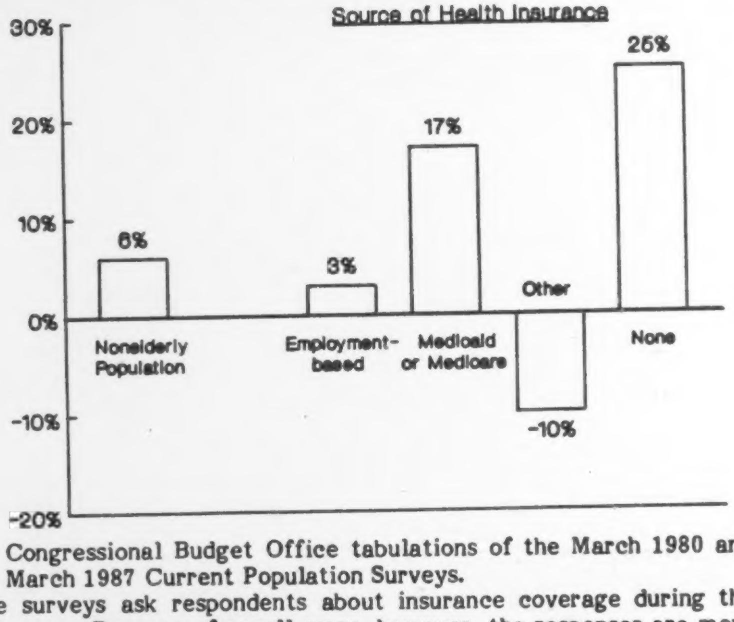
1. The elderly are omitted from this discussion of the problem since they are almost universally insured by Medicare.

Figure 1.

Sources of Health Insurance for the Nonelderly Population, 1987



Percentage Change in the Nonelderly Population and Their Sources of Health Insurance, 1980-1987



SOURCE: Congressional Budget Office tabulations of the March 1980 and March 1987 Current Population Surveys.

NOTE: The surveys ask respondents about insurance coverage during the last year. Because of recall error, however, the responses are more likely to reflect current or recent coverage. Therefore, for example, these figures assume that the March 1987 survey reflects insurance coverage in the early months of 1987.

insurance changed little from 1980 to 1987, a smaller proportion of their dependents had employment-based coverage in the latter year. This lack of coverage for dependents may, in turn, reflect less generous contributions by employers as they attempted to control rapidly rising expenditures for fringe benefits.

The Minimum Health Benefits for All Workers Act of 1987 (MHB) is designed to expand the number of Americans with employment-based health insurance. It would work as follows.

- Each employer would be required to provide health insurance for all full-time employees — defined as those working 17.5 hours or more a week — regardless of any other health coverage they might have. The spouses and dependents of these employees would also have to be covered, unless they were insured by other employment-based plans.
- The act would specify a minimum plan covering inpatient and outpatient hospital care, inpatient and outpatient physician care, and diagnostic tests. Its cost sharing would be limited to maximum annual deductible amounts of $250 per person and $500 per family; a maximum coinsurance rate of 20 percent; and a maximum total out-of-pocket cost of $3,000 per family per year.
- Each employer's plan would have to meet these minimum standards or provide at least the equivalent in actuarial value, with three exceptions. Each plan would have to provide prenatal and well-baby care and none could impose a waiting period for eligibility or exclude coverage for preexisting conditions.
- Employers would be required to pay at least 80 percent of the cost of the plan for most workers, and to pay the full cost for workers earning $4.19 per hour or less. Employees would be required to accept the plan.
- The MHB requirements would apply to all firms covered by the Fair Labor Standards Act.
- Small employers would be required to select from a few plans for their geographic area that would be approved and regulated by the federal government.

- The act would become effective between 12 and 24 months after enactment.

DIRECT EFFECTS ON INDIVIDUALS AND EMPLOYERS [2]

As Table 1 shows, MHB would require insurance for 51 million people, including 23 million — or nearly two-thirds — of those who were previously uncovered. [3] In essence, only individuals and families where no one was employed at least 17.5 hours a week would continue to be without health insurance.

About 29 million of the 51 million people who would acquire new health insurance are already insured to some extent. About 9 million of them are covered by individual policies. Because these policies tend to be relatively expensive and their benefits would generally overlap with those from the new employment-based group insurance, many of the individual policies would probably be dropped by their owners. Since these people would pay at most 20 percent of the new plans' premiums, the direct effect would be to improve their coverage and lower their cost. [4]

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[2] This section discusses the direct effects of MHB under the assumption that the only behavioral changes that would occur would be higher contributions for health insurance paid by individuals and employers as required by the act. The next section considers other possible responses.

[3] Of the 51 million, 33 million, or 65 percent, would be employees and the remainder would be their spouses and dependents. The calculations are based on average premiums of $708 for coverage of individuals and $1,798 for family coverage. These premiums were estimated by the Actuarial Research Corporation.

[4] The following section describes indirect effects that would adversely affect some members of this group.

In contrast, the three million people affected by MHB who currently participate in Medicaid would almost certainly continue to do so, because Medicaid's provisions are more generous than those of most employment-based plans and participation is essentially free. (By law, Medicaid would become the secondary payer for those who acquired private health insurance; that is, Medicaid would be responsible only for care not covered by the private plan.) Thus, members of this group would seldom find their health coverage improved. Moreover, the roughly 40 percent of them who

TABLE 1. PEOPLE AFFECTED BY S. 1265, IF FULLY IMPLEMENTED, CALENDAR YEAR 1988 (In millions) a/

	Workers	Dependents	Total
Total Number Affected by Required Insurance b/	33	18	51
Previously uninsured	12	10	23
Previously insured by non-employment-based source	8	8	16
Previously insured by employment-based source of family member	13	0	13

SOURCE: Congressional Budget Office estimates based on the March 1987 Current Population Survey.

NOTE: Details may not add to totals because of rounding.

a. These estimates assume that people working 18 hours a week or more would be covered by the act, unless they were domestic laborers or they were self-employed but did not employ others in their businesses.

b. An additional 4 million workers would not be subject to the requirements of S. 1265 for their own coverage, because of existing employment-based insurance, but they would have to insure one or more dependents who were not covered under employment-based plans. These workers are not shown in this table as being affected by S. 1265, but their newly insured dependents are counted.

earn $4.20 an hour or more might have to pay the employee's share of the new plans' premiums, thereby reducing the resources they would have available for other purposes. 5/

Finally, for 13 million workers, the new coverage from their own employer would overlap with benefits provided through another family member's employment-based plan. Employees would have to participate in their own employer's plans; whether they would continue to participate as dependents in other plans would depend on whether the additional coverage would be worth the additional premiums they would have to pay, if any.

As Table 2 shows, the act would also require that $27.1 billion in incremental health insurance costs be paid through employment-based plans. These premiums would initially be paid primarily by employers. The bulk of employers would, however, either be unaffected by MHB — because they already offer health insurance plans that would satisfy the actuarial equivalency test — or would just have to add the prenatal and well-baby benefits, for an aggregate cost of about $2 billion. In sharp contrast, employers that would be required to purchase new policies for their workers or dependents would incur direct costs of about $22 billion or about $900 per employee. Because this amount would represent a 12 percent increase in

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5. The impact on the four million participants in other government programs, such as Medicare, which would also become secondary payers, would depend on the government programs' provisions and cost, as well as those of the employment-based plans.

these employees' wages, the affected employers might have some difficulty adjusting in the short run.

Table 3 shows the characteristics of the workers who would be affected by MHB. They tend to be employed by small firms, be concentrated in certain industries, and have lower incomes. Overall, only 29 percent of all workers would be affected by the act, compared with nearly 60 percent of those who work for firms employing fewer than 25 people. Nonetheless, 19 percent of employees who work in firms employing 1,000

TABLE 2. INCREMENTAL HEALTH INSURANCE COSTS PAID THROUGH EMPLOYMENT-BASED PLANS UNDER S. 1265, IF FULLY IMPLEMENTED, CALENDAR YEAR 1988 (In billions of dollars)

Total a/	27.1
New policies	25.1
Employer contributions	21.8
Employee contributions	3.3
New benefits under existing policies	2.0

SOURCE: Congressional Budget Office estimates based on the March 1987 Current Population Survey and premiums estimated by the Actuarial Research Corporation.

NOTE: Details may not add to totals because of rounding.

a. These estimates exclude the cost of policies that would cover workers who were previously insured under plans based on the employment of other family members, because the added cost of these new policies would be approximately offset by reduced costs of benefits under the family members' current plans. The costs of policies for workers previously covered by individual policies or government programs are included, however, because much of the cost of their health care would be transferred to the employment-based plans.

TABLE 3. PERCENTAGE DISTRIBUTION OF CHARACTERISTICS OF WORKERS AFFECTED BY S. 1265, IF FULLY IMPLEMENTED

Characteristic a/	All Workers b/	Not Affected c/	Affected c/
All Workers	100	71	29
Size of Firm			
Under 25 employees	100	42	58
25 - 99	100	63	37
100 - 499	100	74	26
500 - 999	100	79	21
1,000 or more	100	81	19
Industry			
Agriculture	100	38	62
Construction	100	62	38
Finance	100	76	24
Manufacturing	100	84	16
Mining	100	85	15
Public Administration	100	87	13
Retail Trade	100	49	51
Services			
Professional	100	71	29
Other	100	53	47
Transportation	100	83	17
Wholesale Trade	100	80	20
Family Income (in 1986 dollars)			
Under $10,000	100	33	67
$10,000 - $19,999	100	64	36
$20,000 and over	100	75	25

SOURCE: Congressional Budget Office tabulations of Current Population Surveys — May 1983 for firm size and March 1987 for industry and family income.

NOTE: Details may not add to totals because of rounding.

a. This table does not show several other characteristics of workers, since they do not differ much for those who would and would not be affected by S. 1265. These characteristics include age, sex, and geographic location.

b. Includes all workers who would potentially be affected by S. 1265.

c. Workers who would not be affected are those currently covered by employment-based health insurance provided by their own employer or union. All other workers would be affected, regardless of any employment-based coverage through a family member's policy or any coverage not based on employment.

people or more would also acquire new coverage. 6/ Similarly, over 60 percent of all agricultural workers would be affected, as would about half of those in retail trade and nonprofessional services, compared with less than 20 percent of employees in manufacturing, mining, public administration, and transportation. About 67 percent of workers with family incomes below $10,000 would be affected, compared with only 25 percent of those with family incomes of $20,000 or more.

INDIRECT EFFECTS ON LABOR MARKETS AND GOVERNMENTS' BUDGETS

Employers could respond to a requirement that they provide health insurance in several ways that, in aggregate, might affect the economy, especially the labor markets for low-wage workers. In addition, both spending and revenues for the federal government and the states would change. Analyzing such effects is extremely difficult, however, and the results are sensitive to a number of assumptions.

Economic Effects

The immediate effect of MHB would be to raise employers' costs for health insurance, if they did not already offer plans that met the act's requirements or if their employees were not enrolling themselves or their spouses and dependents. If the affected employers did nothing in response, their profits would fall by the amount of their additional contributions.

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6. Congressional Budget Office estimates based on the May 1983 Current Population Survey, the most recently available one that gathered information on the sizes of firms.

Alternatively, over time, they might raise the prices of their products or reduce their employees' compensation, compared with the levels they otherwise would have attained.

Although the exact division among these alternatives is not known, employers would almost certainly strive to minimize the impact on profits. Because raising prices would reduce sales of their products, affected employers would probably adopt this strategy only to the extent that they could not shift costs to their employees. This shift could be accomplished by limiting wage increases, by reducing fringe benefits of other types than health insurance, or by cutting the quantity of labor employed. Because most of the workers who would be affected receive little or no compensation in the form of fringe benefits, the long-run effect would be to lower wages by about the amount of employers' required contributions.

Wages could not decline this much, though, for workers earning at or just above the minimum wage. The top panel of Figure 2 shows three versions of employer's hourly costs for workers with hourly wage rates ranging from $3.35, the current minimum wage, to $4.50. 7/ The bottom

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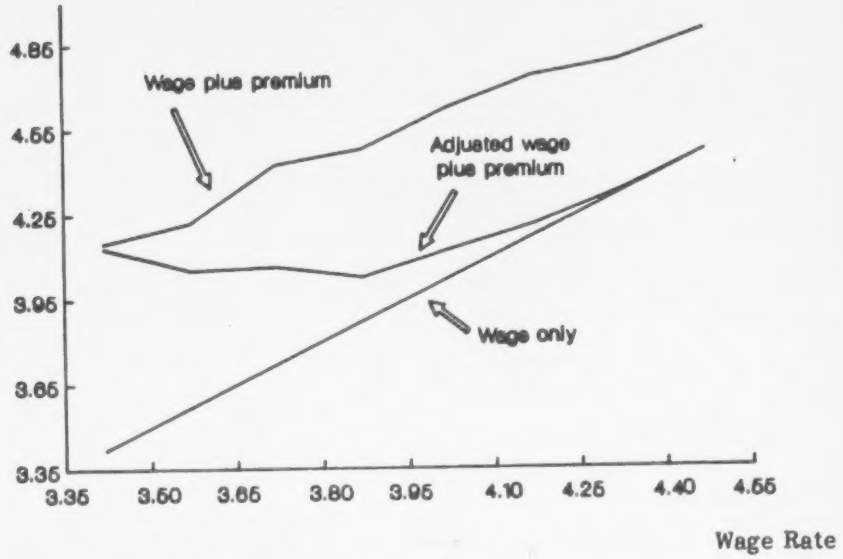
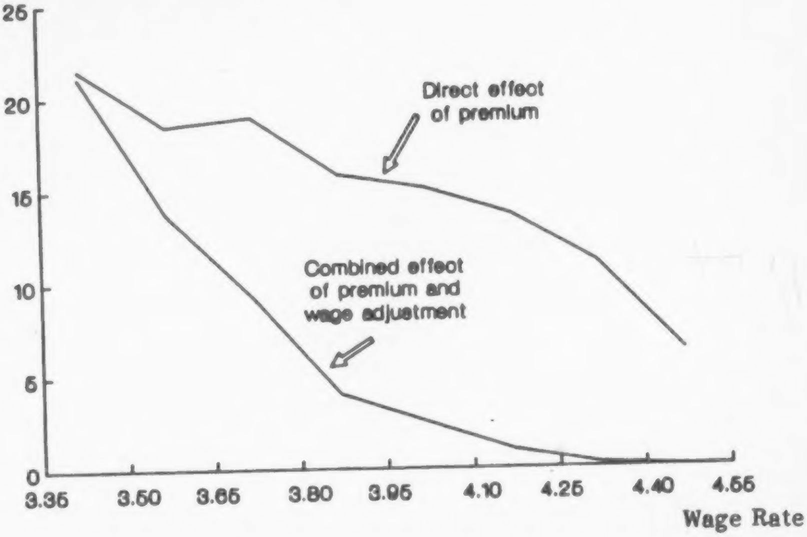
7. Figure 2 is based on simulations using information about wage rates, hours worked, and family structure from the March 1987 Current Population Survey and premiums estimated by the Actuarial Research Corporation. The increase in an employer's average hourly cost that would result under MHB would vary with the wage rate, because people earning higher wage rates work more hours per week, on average, than those earning less. Consequently, a fixed premium for health insurance would increase higher hourly wage rates by fewer cents per hour than it would raise lower hourly wage rates.

Figure 2.

Employers' Cost Per Hour of Wages and Health Benefits Required Under S. 1265, for Low-Wage Workers



Percentage Increase in Employers' Cost Per Hour Under S. 1265, for Low-Wage Workers



SOURCE: Congressional Budget Office calculations using information about wage rates, hours worked, and family structure from the March 1987 Current Population Survey and premiums estimated by the Actuarial Research Corporation.

line shows these costs, if compensation consists of wages only. The top line includes the additional cost of the premiums the employer would be required to pay under MHB. The middle line shows how much lower the sum of wages and premiums could be, if wages fell to offset fully the new premiums but were not allowed to fall below the minimum wage. In this case, workers who previously cost the employer $3.35 per hour would now cost about $4.00 per hour, as would most workers who were previously paid between $3.35 and $4.00. Since workers earning lower wages are generally less productive than those earning more, the interaction of MHB's provisions with the minimum wage would put currently uninsured low-wage workers at a strong disadvantage in the labor market.

The bottom panel of Figure 2 makes this point in somewhat different terms. The top line shows that the direct effect of MHB would be to add about 20 percent to the hourly cost of workers paid the minimum wage, compared with roughly 10 percent at $4.30 per hour. The bottom line shows the more dramatic difference in labor costs that would occur if employers shifted as much of the increased premiums as possible to employees through lower wages. The lowest-wage workers would still become 20 percent more expensive, whereas there would be almost no effect on the cost of those previously earning over $4.00 an hour.

These changes in employers' relative costs could, in turn, cause some disemployment — either through layoffs or reductions in hours — of the approximately 6 million workers who now earn under $4.00 per hour and would be affected by MHB. Also, employers could recast 20-hour-per-week jobs as 17 hours per week, or change full-time jobs into part-time jobs of 17 hours a week or less, to avoid providing health insurance. From a different perspective, employers with high proportions of low-wage workers might find it difficult to adjust sufficiently before the act became effective to avoid lower profits. On the other hand, these adverse effects on employees and employers might diminish over time, if the minimum wage were not raised in concert with inflation and productivity growth in these jobs.

These adverse effects on some low-wage employees and some firms might be mitigated, if S. 1265 were modified somewhat. For example, the time between enactment and the act's effective date could be lengthened, to give employers longer to adjust. Alternatively, low-wage workers might be liable for some of the required premiums — up to 10 percent, for instance —rather than requiring firms to pay all of the premiums for workers with wages under $4.19 an hour. Or, newly established businesses might be exempted for a certain number of months. On the other hand, these alternatives would delay the expansion in coverage, shift more of the health insurance costs to low-wage workers, or provide fewer people with coverage.

Budgetary Effects

As Table 4 indicates, MHB would have little effect on the federal budget. If it were fully implemented for 1988, outlays for health care would decline by about $5.1 billion that year, but revenues would fall by around $5.0 billion, for a net impact of reducing the deficit by roughly $100 million. In keeping with the Congressional Budget Office's general practices, these estimates are static — that is, they consider the direct changes in behavior that would result from requiring health coverage for workers and their immediate families, ignoring successive rounds of behavioral responses that might ensue. The estimates assume, however, that total wages would fall by the full amount of the premiums required of employers.

TABLE 4. EFFECTS ON THE FEDERAL BUDGET OF S. 1265, IF FULLY IMPLEMENTED, CALENDAR YEAR 1988 (In billions of dollars)

Effect	Magnitude
Change in Federal Deficit	-0.1
Outlays a/	-5.1
Medicare	-3.2
Medicaid	-1.1
Department of Defense	-0.8
Revenue Loss a/	5.0
Individual income tax	2.2
Social Security and Medicare payroll taxes	2.8

SOURCE: Congressional Budget Office estimates based on the March 1987 Current Population Survey, a sample of 1985 Medicare claims data, the 1984 Health Interview Survey, and premiums estimated by the Actuarial Research Corporation.

NOTE: Details may not add to totals because of rounding.

a. Note that negative outlays reduce the federal deficit, while positive revenue losses increase it.

Spending. Federal outlays for health care would fall, since the new employment-based health insurance benefits would substitute for some now provided through federal programs, such as Medicare and Medicaid. The magnitude of the savings, however, would be quite dependent on actively enforcing secondary-payer provisions. The estimates also assume that all workers would participate in employment-based plans, even though their share of the employment-based premium — up to 20 percent of the total or about $360 per year for family coverage — might purchase few or no additional benefits for many of them. If these assumptions were not fully met, or if enforcing the secondary-payer provisions raised administrative costs, the savings could be much lower.

Medicare would save about $3.2 billion in 1988, because employment-based plans would be the primary payers for essentially all beneficiaries employed at least 17.5 hours a week. 8/ About 1.7 million Medicare beneficiaries and their spouses would acquire new employment-based insurance under MHB, unless employers responded by hiring fewer workers age 65 and older or by hiring them for at most 17 hours each week.

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8. Medicare is now a secondary payer for employed beneficiaries who choose to participate in their employers' health plans (often called the "working-aged" provision). S. 1265 would require many of them to participate, however, whereas now it is up to each beneficiary.

Private plans would also become the primary insurers for about three million individuals eligible for Medicaid, yielding federal savings of about $1.1 billion. In addition, because the states pay about 45 percent of total Medicaid costs, they would save an additional $900 million. Some state and local governments might also pay less for charity care, although the extent of these savings would depend on how much needed care is not now being provided to those who would continue to be uninsured.

Revenues. Federal revenues would fall by about $5.0 billion, as shown in Table 4 — about $2.2 billion less would be collected by the federal personal income tax and about $2.8 billion less by the Social Security and Medicare payroll tax. Most states would also have lower personal income tax receipts.

These revenue losses would be direct consequences of the differential treatment of wages and salaries — which are taxable — and of employers' contributions for employees' health benefits — which are not subject to either income or payroll taxes. 9/ The portion of the additional premiums

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9. These estimates assume that the act would not change the nominal level of the gross national product and that employers would lower wages by an amount equal to their share of the health insurance costs that would result from MHB. Thus, the taxable wage base would fall by the amount employers paid in additional health insurance premiums. The estimates are not particularly sensitive to the assumption about shifting, however. If only part of employers' contributions were shifted to employees through lower wages, with the remainder paid from profits, for example, revenues from the personal income tax system would not fall as much; instead, corporate income tax revenues would fall.

that would be paid directly by employees would probably not affect revenues, because it would be paid from after-tax income.

CONCLUSION

S. 1265 would resolve a substantial portion of the problem of the uninsured, by assuring that nearly two-thirds of them — 23 million people — would acquire employment-based health insurance. Unfortunately, though, some members of this group -- those earning about the minimum wage — might find themselves either without work or with fewer hours in any one job, so that they would not qualify for insurance in the end. Moreover, employers with high proportions of low-wage workers would find their costs of doing business increased substantially. These adverse effects could be mitigated by modifying the bill's provisions, but then coverage would be delayed or low-wage workers would have to pay more for it.

The CHAIRMAN. I am sure he will be back.

Let me just go through—you have touched on a number of these points, but I would like to get perhaps some additional information from you, because there are points which have been referred to during the course of the hearing this morning, and we will hear a good deal more about them.

You indicated that this proposal virtually has no negative impact on the deficit; is that correct?

Dr. GRAMLICH. Yes.

The CHAIRMAN. And you indicated that——

Dr. GRAMLICH. As far as we can tell. I mean, we are comparing two large numbers, both of which are uncertain, so there would be uncertainty around that estimate, but the mean estimate is close to zero, yes.

The CHAIRMAN. OK. You indicated the cost of upgrading the benefits structure of current plans was relatively modest, about $2 billion, almost all of which went for providing pregnancy and well-baby care. Is that correct?

Dr. GRAMLICH. Yes.

The CHAIRMAN. To pursue that point a moment, many medical authorities believe that prenatal care is highly cost-effective. Did you attempt to estimate any savings from providing this care?

Dr. GRAMLICH. No, we did not. In that sense, that number $2 billion in Table 2 could be viewed as an overestimate.

The CHAIRMAN. Now, the study by IRET that we will hear about from one of our later witnesses puts the cost of the plan upgrades at $16.3 billion. Have you reviewed that study at all?

Dr. GRAMLICH. We have. If you want to get into that, I would like to turn that over to Steve Long, to my right here. He and Jack are the analysts——

The CHAIRMAN. Well, what I am interested in is how you explain the discrepancy between this finding and the CBO estimate.

Dan, we are glad to have you back. We just ascertained that this has virtually no negative impact on the deficit.

Senator QUAYLE. Who are we talking to?

The CHAIRMAN. CBO.

Senator QUAYLE. Oh.

The CHAIRMAN. And that the other estimate about $2 billion in upgrading plans is basically well-baby care, prenatal care, and we did not do an evaluation of what the savings might be because of healthier, lower numbers of low-birth-weight babies; we have about 270,000 of them born each year. So that is probably overestimated.

Let's get into the discrepancy on the upgrading plans, if you would, please.

Mr. LONG. I think to compare our figures with the IRET estimate, we can go through systematically and subtract some sources of difference and get down to the CBO number. We start with their estimate of about $100 billion in added costs to employers. Forty-five billion of their estimate is the cost of duplicate coverage, that is, where someone has previously been covered by another family member's employment-based plan and now, under your proposal, would have to be covered by his or her own employer.

The IRET estimate suggests that that will cost $45 billion. The CBO estimate assumes that that duplicate coverage is largely a wash; that is, through coordination of benefits, activities between insurance companies and the like, that someone who was previously covered under one employment-based plan, many of them are experience-rated and only pay for the benefits that the covered people actually consume, that the cost would go down in the case where the spouse was previously covered and the newly covered costs would go up, but that those costs offset each other, so essentially it is a break-even proposition.

So that would get the IRET estimate down to about $55 billion from its $100 billion beginning.

Then, if you look at their estimate and ours of the cost of upgrading, they estimated that there would be about $16 billion in costs of upgrading, of plans that were below the minimum described in this proposal. Our estimate was, of course, $2 billion. We simply do not see the extent of low-coverage plans out there that they do, so I guess it is simply a dispute about what the facts are. The minimum described in this bill seems, from what we can learn from actuaries and data on insurance plans and whatnot, to be a very lean package and well below the kinds of average premiums that are out there for existing employer coverage.

If we subtract the difference, then, between their $16 billion number and our $2 billion number from the $55 billion that we have reached, that brings us down to about a $40 billion estimate for IRET.

If you look further, then, the next difference between us is on the premiums we assume. They take the average premiums for existing employer coverage and use that as an estimate of the value of what the newly acquired coverage would cost. However, since we viewed this minimum required benefit as being of lower value than the typical existing policy, we think that premium estimate is too high. Our estimate is derived from Gordon Trapnell's numbers—he will be speaking later today—we have given him demographic information on who would be covered, and he has come up with a premium cost that he thinks matches the minimum benefits required.

If you remove that difference, their roughly $37 billion for these new benefits for the newly covered people and our $25 billion, then that difference coming out gets the IRET estimate down to about $29 billion.

And finally, they have a small administrative cost estimate of $2 billion. Our understanding is that the higher administrative costs of dealing with small firms which would be disproportionately covered by this proposal is already in the Trapnell premiums. That is, there is a 15 percent administrative cost assumed in those estimates, and that is what we have used in our work. That explains, then, the difference between their $100 billion and our $27 billion.

The **Chairman**. That is an excellent review.

Let me ask you, Dr. Gramlich, you spent considerable time in your statement discussing the potential disemployment effects for the low-wage workers. It is certainly true that any increase in labor cost has some potential disemployment effects. But in evaluating such effects, we have to look at the amount of disemployment balanced against other benefits. Is that true?

Dr. **Gramlich**. Yes.

The **CHAIRMAN**. Do you want to talk a little bit about the disemployment?

Dr. **GRAMLICH**. The disemployment effects, sure. Well, let's start with Figure 2 on page 12. This is all going to be very rough, and we have not done it carefully. It is not easy to do it carefully. But let us say that for the low-wage workers, we are talking about roughly a 20 percent increase in wage cost. That is what we figured this bill would be at that level. For minimum wages as a whole, a good rule of thumb is that you can use an elasticity of about 0.1, so that if you have a 20 percent increase in wage cost at that level, that would be roughly, say, a 200,000 reduction in employment. But that is for minimum wage as a whole.

Now, as you know, not everybody would be newly covered by this bill. There would be a whole lot of people at that level who already have coverage, and so you are not in effect raising their wage. Indeed, it looks like you are raising the wage of about one third of them as far as we can tell.

So then, just a very crude back-of-the-envelope calculation puts you somewhere maybe 50,000, 100,000, something like that. I would have to do it more carefully. But I think that the number that Professor Davis was using earlier is probably roughly accurate. She was using 100,000. I expect that number to change if we do it more carefully, but I think that is the rough order of magnitude.

The **CHAIRMAN**. Do you include in that the increased number of health workers you would have to hire?

Dr. **GRAMLICH**. It did not include that. This is only the direct——

The **CHAIRMAN**. That figure would be somewhat lower——

Dr. **GRAMLICH**. Well, that is true; but then, of course, there are taxes on the other side. I mean, once you get into indirect effects, there are lots of things that change.

The **CHAIRMAN**. Yes. Senator Quayle?

Senator **QUAYLE**. Thank you, Mr. Chairman.

Have you done, or can you look at for us, the disemployment effect if you would combine both the minimum wage and the minimum health benefits package?

Dr. **GRAMLICH**. I could do it with my back-of-the-envelope calculation, if you want. I could do it, but I would rather do it more carefully.

Senator **QUAYLE**. OK. If you would submit that to us, please.

Dr. **GRAMLICH**. Yes, yes. Senator, if I could just say one thing about that, what we would do, the estimates of the impact of minimum wages on unemployment vary all over the map. There was a Minimum Wage Study Commission a few years ago that did an excellent synthesis of all these studies, and the estimate I used was their mid-range estimate, and we would propose to use that.

Senator **QUAYLE**. The issue that I am grappling with is the economic impact and the employment impact if you combine passage of both the minimum health benefit and the minimum wage. They both amend the Fair Labor Standards Act. They are both before this Committee. If you take them separately, you are going to have different results. What I would like to do is get a combination of the two and have that information available to us.

Dr. **GRAMLICH**. I understand, and we will do that.

Senator **Quayle**. I had to step out for a moment. Did you look at the insurance premiums to see if in fact the premiums that are suggested fit what the benefits call for in the legislation? Have you done a thorough analysis of that to be able to say that the premiums we are talking about do in fact reflect the benefits that are being proposed?

Dr. **Gramlich**. Can I turn that one over to Mr. Long?

Senator **Quayle**. Sure.

Mr. **Long**. We are not actuaries at CBO; we are largely economists. So in fact we did rely on the work of the Actuarial Research Corporation for the calculation of these premiums.

It is not, however, that we did not compare them to other kinds of premiums that are out there, other averages from the economy that we can find. They seemed reasonable to us, but it is really their professional reputation and their work that we relied on. Their premium calculation is one of the sources for our estimate, and it is not a CBO estimate; it is an Actuarial Research Corporation estimate.

Senator **Quayle**. An Actuarial Research estimate—based on one or many or——

Mr. **Long**. They have done a separate estimate.

Senator **Quayle**. Who are "they"?

Mr. **Long**. Actuarial Research Corporation; it is Gordon Trapnell, who will be testifying later.

Senator **Quayle**. Oh, they will be testifying?

Mr. **Long**. Yes.

Senator **Quayle**. OK.

Mr. **Long**. So in fact, he will be able to say more about the work they did. We provided them with information on the characteristics of the people who would be newly covered so that they would know what the age, sex and geographic distribution of the newly covered population was. And they used that in comparison with data we have provided on who is covered now, so that the demographic characteristics could be handled. We provided them with that information as an input to their calculation.

Senator **Quayle**. So you basically relied on the Actuarial Research Corporation, their information.

Mr. **Long**. For the premium.

Senator **Quayle**. For the premium. And I think basically, the bill has, too. I think that is where we get the numbers that they relied on. So we have their testimony, but we really do not have an independent assessment of those premiums from someone else; is that correct? I think that is what you are saying.

Mr. **Long**. Well, it is not an independent professional assessment because we are not actuaries.

Senator **Quayle**. Right. I want to go back to the potential unemployment and the disemployment effects and to look at the characteristics of who these people might be who will be thrown out of a job. I doubt if they are $30,000—$50,000 white collar male——

Dr. **Gramlich**. No, oh, no.

Senator **Quayle** [continuing]. Suburbanites. Who will these people be, even under the minimum calculation?

Dr. **Gramlich**. Well, the logic—I first should say, I suppose, that we do not know for sure—but the logic we followed is that there would be very clear incentives for firms that are under this mandate to try to shift the costs back onto workers, and then it is a question of what gives. If their other fringe benefits can give, then they would give, and maybe there would be very few of those workers who would be thrown out of jobs.

If they are at relatively high wages, say, $4.50 an hour, something like that—that does not sound high to you or me, but it is high for this population—then there would be a relatively modest change in their wage, and we give it in Figure 2 as 5 percent. But if they are at a minimum wage, then the wage cannot give. At that point, if you try to shift the wage down, it becomes illegal. So there, I think, is where you would look for the disemployment impact, and I think it would be on minimum wage workers, yes.

Senator QUAYLE. And on minimum wage workers, you think that would be the basic impact.

Dr. GRAMLICH. Yes, I think that would be——

Senator QUAYLE. Young people, primarily.

Dr. GRAMLICH. Yes, young people, yes; the people in the South—I mean, there are various pockets of low-wage workers around the country.

Senator QUAYLE. So in other words, the people who will lose their jobs will be low-wage workers; you could identify it as such?

Dr. GRAMLICH. Yes, that is right. I mean, that is simply saying that a bill like this is not costless. I mean, there will be people who benefit and people who lose.

Senator QUAYLE. I do not think anybody is saying it is costless. I would have a dispute on what the actual economic impact is. But what I am trying to ascertain for public consumption is the type of person who is going to lose his job. We may talk in terms of 100,000 jobs as not being a lot, but if you take 100,000 jobs of minority teenagers, that population has suffered enough, and I think the bill would have a rather dramatic impact on them. That is why I am trying to determine the characteristics of those people who would lose their jobs.

I would also like to ascertain the characteristics of the businesses that would be impacted most by this. I guess from a logical basis you would take a business that is probably on the margin, a business that does not have a great deal of cash flow, perhaps a business that operates on a month-to-month or six-month-to-six-month basis, and all of a sudden, by mandate, additional costs are imposed on them. Are we not basically talking about companies that are not terribly fluid—probably companies that in many cases are just starting up? Could you give me an analysis or a characteristic description of the types of businesses that are going to be affected most by this?

As I said, notwithstanding that some big corporations and big businesses may not have health insurance, and maybe by choice or otherwise, big business is not going to be impacted by this legislation. I mean, this legislation is not going to hit them right between the eyeballs; it is small business and medium-sized business.

Dr. GRAMLICH. Yes.

Senator QUAYLE. I would like to get a characteristic definition of the businesses that are going to be most impacted by this.

Dr. **Gramlich**. Well, first off, I should say it is a lot harder to do the business side of this than the individual side because of data gaps. But what I think you are driving at, and I think you are correct about that, is that the impact would be disproportionate for small business, because those would typically be the ones who at the same time employ low-wage labor and who would not already have health insurance.

I have one table here that I was given; it is just numbers here, and I do not know how good they are. But it says—and this, I should say, is a policy dimension that you have here, that if, for example, the firms with employees less than 25 were exempted from this bill, then the affected workers would be cut by roughly half. That is an order of magnitude, so roughly half of the workers that you are talking about here where there is a big increase in wage cost would be for low-wage firms.

Senator **Quayle**. For low-wage firms?

Dr. **Gramlich**. Excuse me. For small firms, employing less than 25 employees.

Senator **Quayle**. Small firms.

Dr. **Gramlich**. Yes.

Senator **Quayle**. A general description of that—I suppose, coming from Indiana, agriculture would be a fairly significant category that would be impacted by this legislation?

Dr. **Gramlich**. Small farmers, yes.

Senator **Quayle**. Small farms would be adversely affected.

Dr. **Gramlich**. Yes.

Senator **Quayle**. I have a few other questions, Mr. Chairman, but I know you want to proceed, so I will yield at this time and I will submit them for the record.

[Responses of the Congressional Budget Office to questions submitted by Senators Hatch and Quayle follow:]

CONGRESSIONAL BUDGET OFFICE RESPONSES TO QUESTIONS ABOUT THE EFFECTS OF S. 1265 FROM SENATOR HATCH

1. Dr. Gramlich, the largest insurance program in the country is the Federal Employees Health Benefit program. I have researched their various plans and have found one that is similar to the requirements contained in Senator Kennedy's proposal, the Blue Cross/Blue Shield program. It provides outpatient health benefits with a $250 deductible for single employees and other similar requirements. However, it does have a 75 percent copayment requirement which is 5% lower than S. 1265's requirements.

   This plan provides health insurance to a pool of 1 million people. The cost of this insurance plan for 1988 is $1,300 per year for single coverage and $2,700 per year for family coverage. This plan provides health insurance to a pool of 1 million people.

   Could you provide the Committee with a cost estimate under the model you used if these insurance premium costs were applied?

   The CBO's estimate of the direct cost to employers and employees of new policies under S. 1265 is $25.1 billion, based on premiums of $708 for single employees and $1,798 for family coverage. These premiums were estimated by the Actuarial Research Corporation, based on the specific provisions of S. 1265 and detailed information on the demographic characteristics of the uninsured who would be affected. If premiums of $1,300 and $2,700 had been assumed instead, the direct cost would have been $39.1 billion.

2. I also asked the Health Insurance Association of America to provide me with a cost estimate of the premiums contained in S. 1265. They surveyed 27 members companies and made assumptions based on the average worker and average costs between high and low areas. They provided me with costs of $2,364 per year for family coverage and $870 per year for single coverage with a composite cost of $1,700.

   Could you also provide the Committee with a cost estimate under the model you used if these insurance premium costs were applied?

   The CBO's estimate of the direct cost to employers and employees of new policies under S. 1265 is $25.1 billion, based on premiums of $708 for single employees and $1,798 for family coverage. These premiums were estimated by the Actuarial Research Corporation, based on the specific provisions of S. 1265 and detailed information on the demographic characteristics of the uninsured who would be affected. If the above premiums had been assumed, the direct cost to employers and employees would have been $32.7 billion.

3. **You estimate the cost of the bill at $28 billion. At what point will a shift in costs start affecting employment?**

   As indicated in the section of our testimony beginning on page 10, the principal response of employers affected by S. 1265 would be to shift the costs of health insurance to employees by paying lower wages than would have been paid otherwise. The longer the delay between enactment and the date the law would become effective, the more complete this process would be. For workers at or near the minimum wage, this form of adjustment is not available, except to the extent that wages would otherwise have risen, for example, because of general inflation. At the hearing Dr. Gramlich estimated that up to 100,000 such workers might lose their jobs if S. 1265 were enacted. The effect on total employment in the economy is much less clear, however, since it would be determined by many other forces, including monetary and fiscal policy.

4. **As I understand the cost estimate in your bill, you calculated the number of uninsured workers and multiplied it by a composite cost of the health insurance premium. According to my chart the median cost of individuals who currently have health insurance premiums is roughly $833 in 1985. Under your analysis the composite premium is $1,181. Since there are currently many workers who have health insurance premiums are likely to jump $300 or more if S. 1265 is enacted? Did you include these additional costs in your estimates?**

   Although we have not seen your chart since November 4, it may have confused two different measures of health insurance premiums -- the cost per worker and the cost per individual covered. Attempting to recall the numbers, we think that you observed that about 165 million people were covered by private insurance at a cost of roughly $135 billion, or about $833 per individual covered. You then compared this $833 per person to the $1,181 per worker cost that was provided by Senator Kennedy in an early fact sheet about S. 1265. Finally, as we recall, you argued that S. 1265 might require over $300 ($1,181 minus $833) in added costs for each of the 165 million people already insured. This seems to be the concern implied by this question, as well.

   In order to clarify the comparison between current law costs and the costs of the minimum health benefit, we suggest two ways of looking at the numbers. First, CBO estimates that 39 million people would be insured by new employment-based policies (see Table 1 of the testimony), at a cost of $25 billion, or about $640 per person. This amount is lower than your 1985 figure of $833 per person, because the minimum health benefit that would be mandated by S. 1265 would be less generous than most policies currently offered by employers. To look at this another way, CBO estimates that about 20 million workers would be covered by the policies costing $25 billion, for a per worker cost of about $1,250. (See Table 1 and Table 2 of the testimony. The $1,250 is a revised estimate that was previously $1,181; the $1,250 figure reflects Trapnell's updated estimates of the premiums under S. 1265 that were prepared for the November 4 hearing.) The $135 billion of private insurance, covering 165 million people, mostly reflects employer group insurance held by about 80 million workers, for a per worker cost of roughly $1,700.

We did not include any additional costs for improvements to existing employment-based insurance in our estimates, except for the $2 billion shown in Table 2 for adding the required prenatal and well-baby benefits. The reasoning behind this assumption is that current policies are more generous than the minimum specified by the bill (which is reinforced by a correct reading of the numbers in your chart), so they would meet the actuarial equivalency test.

5. **Dr. Gramlich, in your estimate of the deficit impact of this legislation, did you factor in any loss of employment?**

   The CBO does not include macroeconomic considerations in its cost estimates or other impact analyses of proposed legislation. In the present context, even if there were some disemployment of low-wage workers, the total level of economic activity would be determined by many other forces, including monetary and fiscal policy.

6. **Do you have any idea how long it will take for firms to transmit the cost of the additional benefits to the employees? Can we expect firms to retard salaries over the two year delay period following enactment of this legislation, in order to start reducing take home pay or other benefits in anticipation of the additional costs?**

   Yes, firms would be expected to begin the process of wage adjustments during the phase-in period. If inflation continues at just under 5 percent per year, it would take between 1 year and 3 years of wage freezes to "finance" the percentage increases in employee compensation per hour shown in Figure 2 of our November 4 statement for all but the lowest-wage workers.

7. **Even the proponents of this measure admit that it will cost in the neighborhood of $25 billion. What provision in the legislation or example from known insurance history justifies the rationale that this cost will be offset in large part by reductions in employer paid health premiums which have been inflated due to uncompensated care?**

Part of the $27 billion in direct costs to employers and employees under S. 1265 would represent changes in who pays for health care that would have been provided anyway, while the rest would represent new spending on health care. The $2 billion in prenatal and well-baby care largely would replace families' out-of-pocket spending for these services under current law. About $5 billion of the employer payments would otherwise have been made by Medicare, Medicaid, and the Department of Defense (see Table 4 of the testimony). Roughly another $3 billion would have been paid by individuals for other nonemployment-based health insurance plans. Finally, the 23 million uninsured people who would be covered by S. 1265 otherwise would have used some medical care -- either paid for out-of-pocket or provided without payment by hospitals and physicians. Although its value is difficult to estimate, this care might account for an additional $5 billion to $7 billion. The remaining $10 billion or so reflects spending for health care that otherwise would not have been provided.

Some portion of the $5 billion to $7 billion of care the uninsured would have received anyway was probably financed by providers shifting these costs to private insurance payers. Whether or not these "cost shifts" would disappear under S. 1265 would primarily depend on hospitals' behavior. If they took on no other uncompensated care patients, then they might reduce their charges to private insurance (or at least not raise them as rapidly). Alternatively, they might treat other uninsured patients from the remaining pool of 14 million such people. In any case, however, the reductions in insurance costs to other employers from doing less uncompensated care could amount to not more than a small fraction -- perhaps 10 percent to 15 percent -- of the $27 billion in direct costs of S. 1265.

8. **Could you submit for the record other options which would provide access to health care for those people currently uninsured which will have a less costly impact on the economy?**

Providing access to health care for the 37 million uninsured people would surely result in higher spending on health care. One dimension that distinguishes options is who would pay for that care. Under S. 1265, the cost of health insurance ultimately would be borne by those who receive the benefits--

the workers themselves through direct payments and lower wages. Under other approaches, the costs might be shifted variously to consumers, businesses, or general taxpayers.

Mandated employment-based insurance coverage would expand health insurance coverage in the workplace, where most people currently get their coverage. Because roughly two-thirds of the uninsured are workers or dependents of workers, this type of expansion has the potential of substantially reducing the number of uninsured. No other single approach, short of national health insurance, would cover so many people.

Other approaches, or combinations of them, might be adopted, either instead of or in addition to a mandate such as is contained in S. 1265. Each of them would address particular populations, many of which are relatively small.

Voluntary approaches to providing health insurance include, for example, subsidized state risk pools and tax credits to encourage the purchase of insurance. Both would help primarily those who perceived themselves to be most likely to need substantial amounts of medical care -- that is, they would experience adverse selection. Expanding the Medicaid program, as another illustration, would cover more low-income, uninsured people but would not deal with nonpoor, uninsured workers and their families unless the program's income eligibility limits and categorical restrictions were substantially relaxed.

This response should not be interpreted as advocating any particular approach. Whether or not more health insurance coverage is worth its costs and, if so, who should pay for it are decisions to be made by the Congress that cannot be answered by analysis. There are, however, certain aspects of S. 1265 that could be modified to reduce its possible economic effects -- although generally these choices would reduce the number of people covered or delay the beginning of their coverage.

9. **There are many who believe that this legislation will drive up health care inflation because consumers will be insulated from the real cost of health care. Current estimates indicate that health care inflation runs three times the rate of general inflation. What do you anticipate the result of this legislation will have in the health care marketplace?**

Although the cost of new policies under S. 1265 would be $25 billion, the increment to national health spending would be smaller -- roughly $10 billion to $15 billion. About $5 billion of the new policies would replace spending under federal programs (see Table 4 of the testimony), and another several billion dollars of care that would have been provided anyway would be insured under the new policies. The incremental cost would represent an increase in national health expenditures of only 2 percent to 3 percent -- a small increase in demand in view of the excess capacity in hospitals and our unusually high physician-to-population ratios today. Therefore, S. 1265 probably would not add much to health care inflation rates.

CONGRESSIONAL BUDGET OFFICE RESPONSES TO QUESTIONS ABOUT THE EFFECTS OF S.1265 FROM SENATOR DAN QUAYLE

1. **In addition to S. 1265, the Chairman has proposed increasing the minimum wage. I am interested in your analysis of the employment impact that increases in the minimum wage will have in combination with increases in mandated health costs for employers. In particular, please estimate the impact of such combined increases on minorities and youth.**

It is not possible to estimate accurately the impact on employment of the increases in the minimum wage and the minimum health benefits being considered by the Committee, for several reasons. It has been many years since the minimum wage was last increased and there have been many changes in the composition of the workforce and the distribution of its wages in the interim. Previous estimates of the effect on employment of raising the minimum wage are based on data from over a decade ago and examine instances of relatively small percentage increases in it. Nonetheless, we have prepared the following illustrative calculation in order to respond to your concern.

Based on an examination of all the existing literature, as well as its own analyses, the Minimum Wage Study Commission concluded that a 10 percent increase in the minimum wage would reduce total employment among teenage workers by 1 percent to 3 percent. The Commission concluded that the effect on employment of adult workers would range from job losses for some groups to job gains for others, but that the overall effect on adults, if any, would likely be minimal.

If the midpoint of the Commission's range of response for teenagers is used in combination with recently published totals for teen employment, an increase in the minimum wage from $3.35 to $4.65 in January 1990 would result in lost jobs for about 400,000 teens. As stated at the November hearing, the separate effect of the minimum health insurance provision might be in the neighborhood of 100,000 jobs. It is even more difficult to pinpoint the impact of the combined provisions, since there might be some interactions, but its order of magnitude under this methodology is probably around 500,000.

Admittedly, these are very crude calculations, using outdated elasticity estimates based on changes in the minimum wage that were much smaller than the ones under consideration by the Committee. The "true" elasticities in today's economy for the larger percentage increases now being considered might be either higher or lower than the one used in this illustration.

2. **While S. 1265 mandates that employees accept the coverage and pay for their share of the premium, it does not provide a mechanism to ensure that this is done. It is my understanding that most state wage laws prohibit involuntary withholding of wages other than for taxes and certain other statutory exceptions. What options are there to ensure that the employee contribution and mandate to accept insurance are enforced?**

In estimating the effects of S. 1265, we assumed -- based on our reading of the bill and conversations with majority staff -- that all employers would be required to offer an acceptable health plan and all full time employees would be required to accept it as a condition of employment. The bill allows a plan -- presumably because a sponsoring employer so wishes-- to shift certain costs to the employees, including premiums and cost sharing. The bill also stipulates that employees are liable for such premiums and cost sharing. Our quantitative estimates of the bill's costs and effects assume that these arrangements would preempt state law and are enforceable under existing, or proposed, federal law.

Even if employers could not force their employees to contribute, the enrollment process for health insurance might work very much as it does under current voluntary offerings. New employees would fill out income tax withholding statements, choose a health plan, and enroll for any other fringe benefits being offered. The employer would presumably inform the employee that the firm is required by federal law to offer a health insurance plan and that the employee's share of the premiums can be deducted from each paycheck. Since many employees would view the chance to buy insurance at no more than 20 percent of its cost as an opportunity, voluntary compliance would probably be high.

3. **Absent such a mechanism, how many low-wage workers who will be impacted by this bill do you estimate will participate given their other economic responsibilities?**

The estimates provided in our testimony of November 4, 1987 assume full participation of workers and dependents who would be affected by the provisions of S. 1265. CBO has not estimated the participation rate that might result if employees were allowed to refuse to enroll under S. 1265.

4. **Is it possible for CBO to provide a description of the response of the typical low-wage employee to the costs of S. 1265? Would the typical family reduce expenditures of food, housing to offset the costs? Would this represent a rational economic choice on the part of the employee?**

CBO's simulations of S. 1265 show that for workers earning between $4.20 and $5.00 per hour, the required employee contribution to insurance would average about 2 percent of family income. (Recall that at wage rates below $4.19 there would be no employee contribution.) In combination with the employer share, however, new benefits would represent about 10 percent of family income for low-wage workers affected by S. 1265 -- an amount that would eventually be paid by these families through a combination of direct payments, lower wages than they would otherwise have earned, or possibly, fewer other fringe benefits. Consequently, they would have to reduce other spending or saving.

In concert with mainstream economic thinking, the CBO assumes that consumers spend their household budgets on whatever mix of goods and services will give them the most satisfaction. Since individual tastes and preferences vary, the composition of household spending varies at the same income level. As a result, if S. 1265 were enacted in a modified form that allowed employees to participate on a voluntary basis, some workers would buy it and others would not. For those who, under this hypothetical situation, would buy less food, housing, and other things in order to acquire health insurance, the response would represent a "rational economic choice." For those who would not voluntarily buy health insurance, S. 1265 would impose a constraint on free choice.

Because S. 1265 is a response to the fact that these workers are generally not offered a choice of health insurance at low group rates, there are no data available that would allow the CBO to assess the proportions of workers who would view S. 1265 as an opportunity or as a constraint. Similarly, CBO has no specific information about how consumption patterns might be affected by S. 1265.

The consumption of many other people, who would not be directly affected by S. 1265, would probably also change. Under current law, the uninsured receive some health care that is paid for by taxes and higher insurance premiums. To the extent that the new insurance under S. 1265 would result in reductions in those taxes and insurance premiums, other consumers would be made better off. Some portion of the increase in their resources would be used to expand consumption of various goods and services.

5. **The introduction of Medicare and Medicaid increased the demand for health services in the later 1960s and 1970s far in excess of the capacity of the health services sector to meet the growing demand. Thus, rapid increases in health care costs followed and continue until today--by the twentieth anniversary of the Medicare program, the cost of the program was eight times its original projections. What will be the impact of this bill on the demand for health services if such historical trends are followed?**

Because several factors are quite different now, historical trends in Medicare and Medicaid spending from 1965 through the early 1980s are not particularly helpful for forecasting added spending under S. 1265. First, S. 1265 would cover only half as many people as were eventually covered by Medicare and Medicaid. More importantly, the working uninsured and their dependents would have per capita health costs that are only a fraction of those for Medicare and Medicaid enrollees. CBO estimates that national expenditures would increase by about $10 billion to $15 billion under S. 1265 -- that is, only by 2 percent to 3 percent -- if it had been fully implemented for 1988. Also, the implementation of Medicare and Medicaid was accompanied by expanding private insurance for the employed population that added significantly to the expansion in demand for health care and the upward pressure on costs. Finally, a substantial expansion in medical care capacity -- for example, in medical technology -- also occurred during this period. In contrast, although improvements in medical technology are likely to continue, the U.S. population is now largely insured and the current excess capacity of medical care resources such as hospital beds and physicians should act to restrain future cost increases.

6. **Please assess the ability of the firms that will be most impacted by this legislation to pay for the mandated health benefit from profits, price increases and reduced return on investment to owners.**

As indicated in our testimony of November 4, 1987, the CBO believes that employees generally would bear the full cost of the mandated health benefits in the long run, not their employers. Moreover, S. 1265 provides for a 12 month to 24 month lag between its enactment and its effective date, depending on the date of enactment. This period would provide time for employers to adjust compensation packages, hours of work, and the composition of their work force to minimize the short-run impact on their financial position. Several options for further reducing any adjustment difficulties of firms were mentioned on page 14 of our testimony.

7. **How will firms respond to mandated health benefits? To what extent will they reduce the labor force? To what extent will the growth of new entry level jobs be curtailed?**

   The principal response of firms would be to reduce contributions to other fringe benefits or the growth in wage rates. Also, in the case of workers whose normal hours would have been at or near the 17.5 hour threshold, weekly hours might be reduced to avoid the health insurance requirement. Finally, some jobs with wage rates at or near the minimum wage might be replaced with part-time workers, higher-wage workers, or capital investments.

8. **If the firms respond by reducing employment or curtailing job creation, what will be the impact on government expenditures on unemployment and welfare programs?**

   CBO does not take macroeconomic effects into account in doing its cost estimates and impact analyses. In the present context, for example, even if there were some disemployment of low-wage workers, the effect on the total level of economic activity is not known. That would be determined by many other forces, including monetary and fiscal policy.

9. **On pages 7 and 8 of your testimony, you indicate that employers would experience some difficulty in adjusting to the costs of this bill in the short run. How do you define the term "short run"?**

   The "short run" refers to the period between either the enactment of the legislation or its effective date and the time at which the ultimate adjustment of compensation packages would have been completed. Adjustment difficulties would be smaller, the longer the period between enactment and the effective date because the likelihood would be greater that complete adjustment could take place before firms would face higher premiums. In addition, the faster the rate of growth in wages -- for example, as in periods of higher inflation or higher productivity growth -- the easier it would be to forgo wage increases to finance health insurance contributions. Because, at lower wages, the proposed legislation would require premiums equivalent to about 10 percent to 15 percent of payroll for affected workers, it might take between one and three years for individual firms to make such an adjustment.

10. **Given the precarious economic position of many small firms, could they survive in the short run?**

It is hard to generalize about the exact impact of S. 1265 on firms, whether or not they are "small." The short-run difficulty that would be imposed by the mandated health benefits would be greater the lower the wage rates of their workers, the fewer hours per week their employees work (provided they work more than 17.5 hours per week), the more dependents insured through the firms, the larger the proportion of labor costs to total costs, the longer the duration of any labor agreements that must be honored, and the larger the reduction in sales of their products that would result from price increases.

Because the CBO does not have detailed data on a national sample of firms, no estimates can be made of the short-run impact on firms. However, the impact of the mandated benefits on the total costs of the firm is likely to be considerably less than the 10 percent to 20 percent increases in compensation for low-wage workers shown in the testimony. In particular, compensation is only one of many types of costs that firms incur. Moreover, since most firms that would be affected do not export their products, they would often find that their competitors would be subject to the same required cost increases, leaving their relative position unchanged, although total demand for their products would fall if all firms raised their prices.

11. **Table 4 (page 15) of your statement, states that federal expenditures for Medicare would decline by $3.2 billion under this bill. Is it realistic to assume that employers would continue to employ older and disabled workers, particularly since these individuals would tend to use more health care services and drive up premium costs? Please provide for the record a complete analysis of all the assumptions you used in developing this table.**

The health insurance cost for an older worker, or for that matter any worker or dependent with high health care costs, depends on whether the firm purchases community-rated insurance or experience-rated insurance. If the firm's insurance costs are not determined by the experience of its own employees, then the firm does not pay a higher premium for the employee with significant medical problems.

Under S. 1265, most small employers would eventually be covered under a regional risk pool with a premium that would be set to pay for the experience of all the employers in the pool. If a small employer were to hire a sick employee, the additional medical costs would be spread across all employees of small employers in that region.

On the other hand, most large employers are either self-insured or pay experience-rated premiums. These firms eventually pay for the additional medical costs of high-risk employees, but the higher costs they would face under S. 1265 would not necessarily cause the employer to avoid older workers. First, because older workers are generally healthier than other elderly persons and have fewer dependents, firms would pay less to insure them than might be assumed based on the average medical costs of the elderly. Also, firms would probably not lay off current elderly workers or workers who aged while being employed by the firm. Any effect would more likely occur by not hiring older workers in the future.

12. **Your analysis of the cost of S. 1265 indicates a bottom line cost of $27.1 billion for calendar year 1988. Could you provide out year cost estimates for a five-year period?**

The $27.1 billion was an estimate of the direct impact of the bill on employers and employees, including upgrading of existing policies. Over several years the costs of this bill would be affected by changes in the numbers of uninsured people and changes in the price of insurance. CBO does not routinely project these factors.

The $27.1 billion should not be confused with a CBO "cost estimate" of the effect of S. 1265 on the federal budget. This type of estimate may be prepared when and if the bill is reported out of the Committee.

13. **Your cost estimate includes no reduction in corporate tax receipts. As the new expenditures for health insurance are deductible and many firms cannot legally reduce their wage payment, is that realistic? Further, many firms (I would suggest most) cannot reduce wage rates as a matter of employee relations; shouldn't that factor into the estimate also?**

The cost estimate in the November 4 testimony reflects the effects of a "fully implemented" plan, expressed in 1988 dollars. It was based on the simplifying assumption that total wages would fall by the full amount of the premiums required of employers -- an assumption that we believe to approximate the long-run response to such a plan. In particular, even firms with minimum-wage employees who currently receive no fringe benefits would be able to shift the costs of the mandated health insurance to their employees over time by raising their wages less than would otherwise have occurred because of general inflation. Thus, the total amount of labor costs that would be deductible in the long run would not differ from under current law. Footnote 9 on page 17 addresses the circumstance raised by your question. The estimated revenue loss would not change much if the alternative assumption proposed by your question had been used.

The CHAIRMAN. Thank you.

Would you also give the demographic characteristics of the 24 million Americans who would benefit under this bill? As I understand, 67 percent of those with family incomes under $10,000 would get health insurance who do not get it now; 36 percent of those between $10,000 and $20,000 would get it; and even 25 percent of those over $20,000.

Dr. GRAMLICH. Yes.

The CHAIRMAN. Those are your own figures?

Dr. GRAMLICH. You are correct, right.

The CHAIRMAN. So, as we all anguish about the 50-75,000 who may lose their employment, we find, as we are going to hear later on, about the econometric models over here being 100,000, and the Wharton Model estimate for two years is virtually zero. And we have seen 13 million jobs created in the last four or five years—13 million new jobs—so we are going to lose 50,000, perhaps 150,000 if we get minimum wage and minimum health benefits. I think it is useful to put this in some proportion; 13 million new jobs, and covering 24 million Americans who do not have it today, the estimates are 50,000 to 100,000, or 150,000 perhaps with both. I think that is of some value.

But we will not have you bother listening to Senator Quayle and I debate these issues.

Senator QUAYLE. Oh, come back.

The CHAIRMAN. We want to thank you. I hope as these questions come up, that we will be able to come back to CBO. You have obviously given this a lot of thought.

Dr. GRAMLICH. Thank you.

The CHAIRMAN. On the question of the premiums, as Senator Quayle pointed out, we did try to get an independent actuar to do the estimates. But I understand from CBO that you do not think these estimates are unreasonable. Karen Davis indicated she did not feel that they were unreasonable as a health economist.

Dr. GRAMLICH. That is right.

The CHAIRMAN. And you believe that these are not unreasonable.

Dr. GRAMLICH. We think they are reasonable.

The CHAIRMAN. Just so that we get that on the record.

Thank you very much.

Dr. GRAMLICH. Thank you very much.

The CHAIRMAN. Our next panel consists of three analysts who have looked at this legislation closely: Professor Gerard Adams is on the Economics faculty at the University of Pennsylvania. He is a distinguished econometrician and will report on the results of this analysis of the impact of this legislation using the Wharton School of Economics Model.

Gordon Trapnell is President of Actuarial Research Corporation. He is a distinguished actuary who is consulted broadly in the public sector for Republican and Democratic Administrations alike, as well as many private organizations. He prepared the premium estimates that were used in the development of the minimum health, and he is here to describe the methodology that went into the development of those estimates.

Finally, Gary Robbins is President of Fiscal Associates. He has prepared a critical analysis of the costs and economic impact of the bill.

Senator QUAYLE. Mr. Chairman, unfortunately, I am going to have to depart so I will read the statements very carefully.

There is just one clerical matter I would like to clear up with you. I am glad to see Mr. Adams back. When he testified back on July 17, I sent a letter to you on July 21, asking just two questions of Professor Adams. I want to know when did the Committee forward my response on, and when we might be able to get some sort of an answer. I sent a letter to you on the 21st, and we have not gotten anything back.

The CHAIRMAN. All right. Why don't we check? We will take it up with Mr. Adams—why don't we work that out, rather than taking the time of the Committee?

Senator QUAYLE. Have you gotten the letter from the Committee on those two questions that I asked about on the combination of minimum wage and the health benefits? Did you get that letter?

Professor ADAMS. We have not made a calculation like that, but we can certainly make one.

Senator QUAYLE. Oh. You have not gotten the request from the Committee to answer the two questions I submitted? Oh.

Professor ADAMS. We were unfortunately running behind very badly, and I was asked yesterday about this——

Senator QUAYLE. Oh.

Professor ADAMS [continuing]. And I, too, can make a back-of-the-envelope calculation, but——

Senator QUAYLE. No, no, no, no.

Professor ADAMS [continuing]. But I think I would like to submit a proper calculation.

Senator QUAYLE. I am not faulting you. I think we may have a problem here.

The CHAIRMAN. Well, we will find out and get the information to Mr. Adams if he has not yet received it.

Senator QUAYLE. OK, yes. I sent a letter to you back on July 21.

The CHAIRMAN. Well, it should have gone out. I will find out, if it has not gone out, why it has not.

Senator QUAYLE. OK.

The CHAIRMAN. The Senator is entitled to get that.

Senator QUAYLE. OK, just for the record.

And Professor Adams, I am not faulting you. I think it may be stuck here in the bowels of communication—and that happens, sometimes, things get misplaced. But I just want to point out for the record that I had sent a letter to the Chairman on July 21, and I do not know, maybe you have not even gotten it yet; maybe you have. But there were just two specific questions that I had, and I would just bring that up at this time, and I know the Chair will correct the matter.

The CHAIRMAN. I hope you will extend my good wishes to the Armed Services Committee.

Senator QUAYLE. That is exactly where I am going—can I have your proxy?

The CHAIRMAN. And you will fight the AVA-8.

Senator QUAYLE. Can I have your proxy?

The **Chairman**. Almost—well, we will get into that later. Thank you.

All right. Why don't we start off with Professor Adams.

STATEMENTS OF PROF. F. GERARD ADAMS, PROFESSOR OF ECONOMICS, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PA; GORDON R. TRAPNELL, PRESIDENT, ACTUARIAL RESEARCH CORPORATION, ANNANDALE, VA; AND GARY A. ROBBINS, PRESIDENT, FISCAL ASSOCIATES, INC., ON BEHALF OF INSTITUTE FOR RESEARCH ON THE ECONOMICS OF TAXATION, WASHINGTON, DC, ACCOMPANIED BY MRS. GARY A. ROBBINS

Professor **Adams**. Thank you, Senator, for allowing me to testify on this issue.

I am a macro economist and consequently, I will be brief, and I will simply give you an idea of what happens when we introduce this program into our Wharton Macro Model.

The objective of such a plan is clearly to protect individual workers and their families and so, speaking technically, it applies at what we call the micro level. But as with other programs which are extended to a large part of the population, it may have macro economic implications for inflation, GNP, unemployment, and the budget.

The question is not whether there are such effects, but rather, how large are these impacts; and particularly, do macro economic costs represent serious barriers to the extension of medical insurance to the uninsured.

In order to evaluate the effect of a plan, we have drawn on the Wharton Quarterly Model of the U.S. Economy which, as you know, is a tool which is used by a large number of business firms and Government agencies in forecasting and policy simulation. The model encompasses at the aggregate level the most important structural links and feedbacks of the economy. I must note, however, that in spite of its size and complexity, this model does not have a great deal of sectoral detail, so that it will yield only a broad picture of the macro impacts of a medical insurance plan.

The program represents an expansion of worker benefits providing mandatory employer-financed, 80 percent, and employee-financed, 20 percent medical insurance plan for workers who are not now covered.

The way we see the plan in the operation of the model is that it is largely a reallocation——

The **Chairman**. Excuse me, Professor. We will have a very brief recess; I must take a telephone call.

Professor **Adams**. Fine.

[Short recess.]

The **Chairman**. Excuse me, Professor Adams. Please proceed.

Professor **Adams**. The plan represents largely a reallocation of payments from workers to employer-financed insurance, from Medicare and Medicaid and the CHAMP plan, to insurance, and from charges now being absorbed by hospitals to insurance carriers.

There is likely to be some increase in total outlays for medical care as a consequence of the plan, but that increase has been estimated to be quite small; we have assumed $5 billion, and I believe

Karen Davis was saying somewhere between $5 and $10 billion. That effectively means there will be an impact on aggregate expenditures, but not a very large one.

The cost of the payments supplement to wages paid by the employers is likely in most cases to be passed on by them in the form of higher prices. But if we look aggregatively, the impact on inflation is small. It is worth noting, however, that the program will affect different groups in the economy with considerable diversity. Most workers in manufacturing are already covered by medical insurance; consequently, the program will fall more heavily on the service sector and on small business, as has already been said.

In Table 1 of the materials I have handed out, we show the results of the simulations, comparing a simulation of the plan to the base simulation of the Wharton Model which does not include the plan. I want to briefly summarize those simulation results.

As we have already noted, for some groups, the impact in hourly compensation including supplements may be quite large. But if we look aggregatively over the economy as a whole, we are talking about a small number, consisting of 0.6 percent.

As a consequence, again, if we look aggregatively at the economy as a whole, we find that we get a small increase in inflation of the nature of 0.1 percent in the inflation rate in 1988 and in 1989. By the way, that is essentially an introductory phenomenon as these higher-wage supplements get passed on in the form of higher prices, and once we get beyond 1988 and 1989, there is no net impact on the inflation rate from this phenomenon.

We obtained from the model only negligible changes in real GNP and employment. I was particularly pleased with Karen Davis' testimony this morning and subsequent testimony as well, because effectively, what happens here is that we are talking about a variety of forces, some operating positively, some negatively. Indeed, it is likely that imposition of such a program will cost some jobs. You heard talk this morning of figures like 100,000 jobs. On the other hand, we must be reminded that we are talking about a net increase in medical expenditures of the range of $5 or $10 billion, and that in turn, of course, causes some stimulus to the economy and provides an offset in terms of employment opportunities.

Not surprisingly, when these elements are introduced into the Model, our calculation would suggest that real GNP is not very much affected, and employment and unemployment on balance are not very much affected.

Finally, we obtained a small improvement in the Federal deficit—again, the result of a variety of forces that are operating in the system. There is some gain in revenues. There is some offset by a reduction in Federal expenditures as certain of the expenditures that will now be taken by Medicare and Medicaid will be taken over by the new plan.

Now, effectively, this means that on the macro level, the impact that we observe is very small; it has only a small impact on the price level, little impact aggregatively on the other dimensions of economic performance. The program is best judged in terms of micro outcomes; what it promises in terms of greater security for many workers who are now not covered by health insurance.

Thank you.

The CHAIRMAN. Very fine. Thank you very much.

[The prepared statement of Professor Adams and responses to questions submitted by Senators Hatch and Quayle follow:]

Testimony of F. Gerard Adams

to the

Senate Labor and Human Resources Committee

November 4, 1987

Macroeconomic Impact of Minimum Health Benefits for American Workers Act of 1987 (MHB) Proposal

The Minimum Health Benefits for American Workers Act of 1987 (MHB) proposal extends medical insurance to workers who are presently uncovered. The objective of such a plan is clearly to protect individual workers and their families, in other words, it applies to what has been termed the "micro level". But, as with other programs extended to a large part of the population--in this case affecting some 40 million presently uninsured people—it may have macroeconomic implications for inflation, GNP, unemployment and the budget. The question is not whether there are such effects, but rather how large are these impacts? Do macroeconomic costs represent serious barriers to the extension of medical insurance to the uninsured?

On the basis of simulations with the Wharton Quarterly econometric model of the United States economy, I conclude that the Minimum Health Benefits proposal would have only small effects on the general economy.

The supplements to wages required to finance the insurance program would increase hourly labor costs by 0.3 percent in 1988 and by 0.6 percent in 1989. (I have assumed a program effective n July 1, 1988.)

The program would account for a 0.1 percent increase in the inflation rate during 1988 and 0.2 percent in 1989. (Table 1). That means the inflation rate would be increased as a result of MHB only from an estimated 4.5 percent to 4.6 percent in 1988

TABLE 1

Macroeconomic Impacts of MHB Proposal

Deviations from Base Forecast (Wharton Model)

	1988	1989
Compensation per hour (%)	0.3	0.6
Private Consumption deflator (% rate)	0.1	0.2
Supplements to Wages (billions of $)	9.0	18.0
Unemployment (%)	0.0	-0.01
Federal Surplus (Deficit) (billions of $)	2.8	7.4
GNP (nominal) (%)	0.1	0.3
GNP (real) (%)	0.0	0.0

and from 4.9 percent to 5.1 percent in 1989. The effect on real GNP would be negligible and the impact on unemployment would also be very small, so small that the effect lies well within the rounding error of a macro model. There would be no burden on the federal deficit, in fact, a small improvement.

This analysis would suggest that macroeconomic considerations should not be a barrier to the implementation of the MHB program.

Explanation of the Simulations

In order to evaluate the effect of the plan we have drawn on the Wharton Quarterly model of the US economy, a tool which is used by a large number of business firms and government agencies for forecasting and policy simulation. This model encompasses at the aggregate level, the most important structural links and feedbacks of the economy. It must be noted, however, that despite its size and complexity this model does not have much sectoral detail so that it will yield only a broad picture of the macro impacts of a medical insurance plan.

The MHB program represents an expansion of worker benefits providing a mandatory, employer financed (80%) and employee financed (20%), medical insurance plan for workers who are not now covered. The plan represents a reallocation of payments, from workers to employer financed insurance, from Medicare-Medicaid and CHAMPUS to insurance, and from charges now being absorbed by hospitals to insurance carriers. There is likely to be only a relatively small increase in outlays for medical care (we estimate $5 billion) so that aggregate real expenditures will not be greatly affected.

The cost of the payments, a supplement to wages (80 percent) is likely to be passed on by employers in the form of higher prices. But not surprisingly since the amount only represents 0.6 percent of total wage payments, the impact on inflation is very small. It is worth noting, however, that the program will affect different groups in the economy with considerable diversity. Most workers in manufacturing are already covered by medical insurance, the program consequently will fall more heavily on the service sector. Most workers in a large firm are already covered, the program will affect smaller firms more heavily. This means that some of them will not be able to pass on the higher costs of labor, suggesting that the econometric estimates may well overstate the aggregate inflationary impact of the program.

In Table 1, we show the results of the simulations, comparing a simulation with a MHB plan to the base simulation which does not include such a plan.

The simulation results can be summarized as follows:

— An increase in hourly compensation of 0.6 percent.

— A small increase in inflation of 0.1 percent in 1988 and 1989.

— Negligible changes in real GNP and employment.

— A small improvement in the federal deficit.

On an annual rate basis the program implies an increase in insurance premiums of $28 billion. Of this, $20 billion are paid by employers as supplements to wages. Some of this burden is offset by savings so that the total of supplements to wages is $18 billion at an annual rate, an increase of 0.6 percent in an hourly compensation rates.

Additionally, we have assumed that $5 billion of additional medical expenses will be incurred as a result of the availability of insurance protection. This is the only real increase in resource use directly attributable to the program. Some further increase in consumption may follow from the fact that insurance pays for expenses otherwise falling on individuals, but it is difficult to evaluate how much of this real increase would occur since most such expenditures would otherwise have fallen on the assets (rather than current income) of the payee.

There is a small reduction in government transfer payments ($36 billion) because of the fact that insurance payments will now cover some payments formally made by Medicare-Medicaid and CHAMPUS. The result is a small improvement in the deficit.

Not surprisingly, the inflationary impact of the medical insurance plan is moderate because the increase in labor costs on an aggregate basis only amounts to 0.6 percent. But, as we have noted, the impact is likely to be relatively larger on service sectors where a large share of the presently uninsured are concentrated. The impact on employment in these groups is also likely to be more pronounced than the very small impact on the national aggregate level. On the other hand, given the presently tight labor market situation in many parts of the country for low wage unskilled workers, it is probable that employment will not be sensitive, that instead, the costs of the program will be passed n the purchasers of products and services produced by the newly insured workers.

I conclude, therefore, that from a macroeconomic perspective, the MHB proposal to extend the coverage of medical insurance to presently uncovered workers, has only small impact on the price level, and little impact aggregatively on other dimensions of economic performance. The program is best judged in terms of the micro outcomes which it promises in terms of greater security for many workers who are not now covered by health insurance.

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Answers to Senator Hatch's Questions

Q. Dr. Adams, you testified at our hearing last July on Senator Kennedy's bill to raise the minimum wage. At that time you indicated that the proposed 40% increase in the minimum wage would result in an increase in the inflation rate of about two-tenths percent annually and a disemployment effect of around 200,000 jobs. Inasmuch as this bill would add approximately 50 cents to the mandatory hourly wage, what estimate can you make of the combined effects of these bills should they be enacted into law?

A. See my answer to Senator Quayle's question on this subject.

(Answer to Senator Quayle):

We have done another model simulation of the combination of the minimum wage proposal and the expansion of health benefits. Not surprisingly, the effect is additive so that we find a somewhat larger effect when we combine the programs than we find if we enact only one or the other. Even so, as you can see from the attached table, the aggregate effects are small. Though for some small employers the adjustment may be quite substantial. That would suggest a gradual phasing in of the proposals. We can afford them as a nation, aggregatively, but we may want to ease into them gradually. (see attached table).

Q. Dr. Adams, the health care marketplace is unusual because consumers are shielded by third-party payors to the true costs of such care. In addition, it has been suggested that if people are required to pay higher premiums for health insurance they will want to "get their money's worth" and may actually consume more health care than they would otherwise. What effect would both of these facts have on the inflationary costs of health care, which is already three times the rate of general inflation?

A. The model does not address the question of medical costs directly. This is a highly technical subject and clearly deserves study in its own right. However, I can make the following points:

1. On the basis of the OMB study we have assumed that health care spending will increase $5 billion simply as a result of the fact that some workers now have insurance who did not have it before. This is obviously an approximation, I believe Karen Davis assumed $5 to $10 billion. Most of the expenditures which will be incurred would have been incurred anyway, covered out of government payments, private assets, or absorbed by hospitals in the absence of an insurance plan. What impact will the plan have on medical cost inflation? My impression is not very much because there is substantial overcapacity in the medical care field. Some people have argued that there may well be an easing of pressures on medical costs

as a result of the plan:

a. because of better utilization of hospital facilities, and

b. because absorption of costs incurred by indigent patients actually causes medical care for those who are able to pay to be more costly.

Q. Dr. Adams, do you have a health sector equation in the Wharton Model, or are these estimates based on your judgment abcut the impacts on labor markets?

A. Certain variations of the model has some health sector equations. But these are largely linkages back to the more aggregated part of the system. Consequently, they do not offer much additional information The effect on labor markets is not just judgment, however. It is important to remember that we are dealing with a very complex, highly interactive economy. What happens in the health care sector and what happens to employment in certain sectors directly affected by the change in the law, is only one part of the story. Some of the losses in employment in parts of the economy are offset by gains elsewhere, for example, when medical spending increases. The model is able to take this into account whereas a narrow sectoral focus misses these feedbacks.

Q. Dr. Adams, can you provide us with the confidence interval for your estimates?

A. Unfortunately, it is very difficult, if not impossible, to provide a confidence interval for these estimates. We are confident that the structure of the system is reasonably well represented, and the performance of the model over time reassures us in that regard. And the model is used widely for policy simulation by many government agencies. When we deal with specific sectors and with specific-sectoral responses we are on much thinner ice. The model assures that we are doing the job consistently, and that the principal interrelationships are taken into account. On the other hand, the behavior which is described by the model and which is introduced into it--for example, the $5 billion increase in spending for medical care noted above--is pretty uncertain. In that case we rely as much as possible on expert information and the available historical data. A sensitivity analysis which might try alternative values of the external inputs and perhaps even of the behavioral coefficients in the model would produce a band of outcomes, but I doubt that it would produce results which are significantly qualitatively different.

TABLE 1

Macroeconomic Impacts of Coordination of MHB Proposal and Minimum Wage Increase
Deviations from Base Forecast (Wharton Model)

	1988	1989
Compensation per hour (%)	0.8	1.5
Private Consumption deflator (% rate)*	0.2	0.5
Supplements to Wages (billions of $)	10.0	21.0
Unemployment (%)	+ .01	+ .02
Federal Surplus (Deficit) (billions of $)	1.6	5.0
GNP (nominal) (%)	0.2	0.5
GNP (real) (%)	0.0	- 0.1

*Note the inflation rate goes up 0.2 to 0.3 percent annually.

Answers to Senator Quayle's Questions

Q. Mr. Adams, you state that the proposed increase in the minimum wage will result in an increase in unemployment of no more than 0.1 percent, the equivalent of about 100,000 jobs lost to the economy. I assume these job losses are not distributed equally among demographic groups. Please give us your estimate of the impact of this loss on minorities and youth.

A. Unfortunately, the econometric model does not break down job losses by demographic group. You are right that the impact is likely to be unequal among demographic groups with more impact among the individuals who are at or near the minimum wage level. Thus, an increase in the minimum wage may fall more heavily on young people and members of minority groups. The question here is not one of whether there is likely to be an impact, but rather how much of a job loss there is likely to be. Our evaluation suggests that the job loss is not going to be all that large for the following reasons:

1. In many parts of the country, there are already shortages or unskilled workers. This situation is likely to get worse as the smaller birth cohorts reach working age during the next few years.
2. The fact that there are unskilled workers out of work at the same time that there is a labor shortage suggests a mismatch between the available workers and jobs. Many of the young people lack the basic skills required even for unskilled employment and many are located in the wrong places. They are not out of work because the wage is too high. This represents a serious social problem, but one that is not affected by the minimum wage. It calls for a national program of job training and relocation.

Q. The attached chart breaks down the cost of the minimum wage increase, and the mandated health benefits proposal, both of which have been proposed by the Chairman of this Committee. I am interested in your analysis of the impact that increases in the minimum wage will have in combination with increases in mandated health costs for employers.

A. We have done another model simulation of the combination of the minimum wage proposal and the expansion of health benefits. Not surprisingly, the effect is additive so that we find a somewhat larger effect when we combine the programs than we find if we enact only one or the other. Even so, as you can see from the attached table, the aggregate effects are small. Though for some small employers the adjustment may be quite substantial. That would suggest a gradual phasing in of the proposals. We can afford them as a nation, aggregatively, but we may want to ease into them gradually.

The CHAIRMAN. We will continue with the panel.

Mr. Trapnell?

Mr. TRAPNELL. Thank you.

I am Gordon Trapnell, a Fellow of the Society of Actuaries, and President of the Actuarial Research Corporation.

The CHAIRMAN. Mr. Trapnell, just at the start of this, as I understand, you provide this service for various groups and for members of the Congress and of the Senate in different legislation, both Republican as well as Democrat; is that correct?

Mr. TRAPNELL. Yes, sir, over many years. I have really had three different careers: one, with an insurance company; one, as a Government actuary, and now, as a private consultant with a small research and consulting firm. Among other things I have done is prepared cost estimates for the Social Security Administration, who used to conduct the Medicare programs.

For example, at the end of one Reconciliation meeting between the Senate Finance and House Ways and Means Committees in 1972, Mr. Mills and Senator Long literally sent me into a back room and said, "Set the right tax rates." (For the next 25 years for the Hospital Insurance program, including disabled and renal failure beneficiaries.)

The CHAIRMAN. So you're the guy who is responsible. [Laughter.]

Mr. TRAPNELL. That was an opportunity I did not want to miss. I set some real good tax rates, and I would like to point out that the tax rates for the Hospital Insurance program have not been changed materially, and they are still expected to be good through 1998, when they were expected to be.

The CHAIRMAN. All right.

Mr. TRAPNELL. I think you probably remember me best as the one who estimated the cost of the Health Security program as costing something like $120 billion.

The CHAIRMAN. I still remember that.

Mr. TRAPNELL. In 1977, when numbers like that used to scare people.

The CHAIRMAN. OK. Thank you.

Mr. TRAPNELL. My firm was retained by the staff of this Committee to estimate the average premium rates that employers would have to pay to meet the minimum standards of S. 1265.

The primary purpose of our estimates was to provide data needed by the CBO analysts in estimating the costs and economic effects of the bill. Since our primary objective related to estimating the overall economic impact of the bill, our analysis began with estimates of the aggregate spending for health insurance by employer-sponsored health insurance plans—that is, by employers and through employee contributions.

We utilized estimates that have been prepared previously for the Department of Health and Human Services in connection with an analysis of the effect of limiting the deductibility of employer contributions to health insurance and taxing the excess over dollar caps.

We projected those estimates to 1988 and combined them with the most comprehensive national database available that includes information concerning spending for health services, employment, the demographic and economic characteristics of households, and coverage by private insurance—that is, the National Medical Care Expenditure Survey (NMCES).

Since the National Medical Care Expenditure Survey was conducted in 1977, we had to project it, or "age" the file, to 1988. We first adjusted the population weights to match the composition of the population in 1988 according to the official projections of the population used by the Social Security Administration actuaries. We then scaled all of the spending for health care services on the file to reflect the mean expenditures per single employee and per covered employee with a family that we found in our work with the employer-sponsored health insurance that we did in connection with the tax cap proposals.

We then had a file that would reproduce our estimates of employee-sponsored health insurance in 1988 and had all of the demographic, economic, and coverage information that is on the NMCES file.

We used this file to estimate average premium rates for various groups in the population, for various types of plans that were considered by the Committee staff in designing the bill.

Since completing these estimates, I have become aware from actuarial colleagues that the cost of health insurance had been rising at an unexpectedly high rate during the last year, and that they expected this trend to continue into 1988.

I have adjusted my estimates upward by 10.25 percent to reflect these trends.

I would like to comment on several reasons why the average cost per employee numbers that we have produced would be expected to differ from premium rates an insurance company might quote.

The first relates to the payment basis. In today's competitive markets, only a minority of payers actually pay the charges. Further, as the number of payers who get discounts grows, the hospitals tend to raise the charges more to make up for the lost revenue.

Consequently, since our estimates reflect this average payment rate of all nongovernmental payers to the hospitals, they would be lower than rates of an insurance company that is paying full charges.

Another item would be the way we have handled bad debts. Hospitals are not paid for some 5 percent or so of services that they furnish, and they have to raise charges to other payers. But many of the hospitals are nonprofit hospitals whose revenues are set by their overall outlays and would not be expected to raise charges as much if those bad debts were paid. Since the bill results in paying a substantial proportion of bad debts, this is netted out from the increase in hospital outlays.

Another item is the way that coordination of benefit provisions tend to affect insurance plans. "Coordination of benefit" refers to the reduction of benefits paid if there are multiple insurers paying for the same services. There are two types that are primarily used—one which is sometimes referred to as a "benefits bank", which reduces the total payment from all insurers to the total outlay for covered services; another more stringent form called a "carve-out", where payments are reduced so that the reimbursement received by the insured is reduced to what would have been paid by the most favorable plan.

The bill would permit either. Currently, however, in small employer markets, there is almost no coordination of benefits because small employers are not willing to pay a premium for somebody who already has coverage from another employer. This is known as being the "shifter" instead of the "shiftee" and small employers are in a particularly good position to do that.

Under the bill, they would no longer be able to do this, and there would be substantial coordination of benefit savings for the small employment market as well.

I would also point out that the characteristics of persons presently uninsured would tend to make them less expensive than those who presently have insurance. They tend to be lower-income, to live in areas where health care costs are lower, and the anti-selection against insurance companies that occurs by those people who need insurance and those tending to seek it tends to make them lower-cost groups.

I would also point out that one particular type of insurer, the Blue Cross and Blue Shield plans, tend to operate in a way that provides coverage for large numbers of small employers who would be given sharp rate increases by most other insurers. This tends to increase their average cost. They are in effect, in many States, operating pools that are subsidized by higher premiums charged to career employers.

I would also note that in our estimates, we were looking at the long-term equilibrium situation. We did not include any margins for the uncertainties that insurers might face in setting premium rates for the coverage of this bill. We also might say that we assumed that the conditions for participation would be sufficiently competitive that participating insurers would be forced to bid premiums based on their best estimates, with little or no margins for safety.

Thank you for this opportunity to testify.

The CHAIRMAN. Fine. Thank you very much.

[The prepared statement of Mr. Trapnell and responses to questions submitted by Senator Hatch follow:]

Premiums for Employer Minimum Insurance Coverage

Gordon R. Trapnell, F.S.A.
President, Actuarial Research Corporation
Annandale, Virginia

Testimony before the U.S. Senate Committee on Labor and Human Resources

November 4, 1987

Premiums for Employer Minimum Insurance Coverage

Objective

The Actuarial Research Corporation (ARC) was retained by the U.S. Senate Committee on Labor and Human Resources to provide estimates of the average premium rates that employers affected by the mandate would pay to meet the minimum standards of S. 1265. These premiums were to be incorporated into analysis prepared by the Congressional Budget Office of the cost and economic effects of the bill.

The proposal specifies that the minimum required package would consist of medically necessary physician care, hospital care, diagnostic tests, and pregnancy and well-baby care. Co-payments would be 20 percent on all services and deductibles would be a maximum of $250 per individual and $500 per family. There would be a required stop-loss "catastrophic" limit for covered services of $3,000 per family. In addition, prenatal and well-baby care would be provided without co-payments or deductibles. All benefits except prenatal and well-baby care would be subject to an actuarial equivalency test that would allow higher deductibles and co-payments to be applied if additional benefits were offered.

ARC provided the requested estimates of premium rates, utilizing the ARC rating model, derived from various data sources including the National Medical Care Expenditures Survey, the RAND Health Insurance Experiment, and the National Health Expenditures estimates of the Department of Health and Human Services. The techniques used in developing the ARC model are similar to those used by our firm to estimate the cost of national health insurance proposals in past years for both the Administration and Congress. We have also tested the techniques involved in preparing estimates of the cost of private health insurance programs for a number of private sector clients.

Sources and Methods

The analysis began from estimates of aggregate spending by employers for health insurance that were provided to the Department of Health and Human Services in connection with a study of the effect of proposals to limit the deductibility of employer contributions to health insurance. Means for the cost of single and family employer provided coverage were used to scale distributions of expenditures for hospital and physician services for employed persons covered by health insurance from the National Medical Care Expenditures Survey to 1988 levels. The resulting distributions were used to estimate the benefits payable under employer health insurance plans with specific cost sharing features, i.e. deductibles, coinsurance rates, maximums on out of pocket expenditures, limits on reasonable charges, etc. and to estimate the effect of cost sharing on the utilization of health services.

Since the analysis was completed, there has been evidence of a sharp increase in the inflation rate affecting the cost of hospital and physician services. For example, many health insurers are now incorporating trend factors in the 16% to 20% range and raising premium rates by much larger amounts. The higher rate of inflation is expected to persist beyond 1987. When data reflecting these recent trends is substituted into the estimates for the increase that has occurred from 1986 and extrapolated to continue through 1988, the estimates are increased by 10.25%. Since the change was to the trend factors, all estimates were increased by the same amount. I understand that this higher trend has already been incorporated into the CBO analysis.

Analysis of regional pools for small employers

Although the ARC premium rates were incorporated into the CBO analysis for all firms offering or upgrading coverage as a result of the mandate, much interest has been centered on the provisions made in the bill for coverage of small employers in regional pools to be established under S. 1265. Small employers (less than 25 employees) that do not now offer health insurance would be required to join the regional pools, through which insurers would offer competing options. The choice of option would be made by the employers in annual enrollment periods. There would be no pre-existing condition clauses or screening of applicants. Based on our understanding of the proposal derived from meetings with the Committee staff, we have derived estimates of the average cost to small employers to purchase the insurance through the regional pools.

The system of regional contractors described in the bill should reduce the cost of health insurance provided to small businesses with less than 25 employees compared to the average cost of purchasing comparable insurance under current market conditions. This reflects our projection that administrative costs would average around 13% of premiums under the proposed system of competitive offerings by regional contractors that eliminates screening of new applicants and the cost of agents' commissions and other sales and placement expenses. We estimate the average cost of administering small group cases under current conditions as over 20% of premiums (and up to 50% of premiums for the smallest groups). Additional savings may be obtained through participation by HMOs and PPOs in the regional offerings, and the incentive that employers have to minimize their outlays.

I estimate the annual per worker cost of an employer-provided insurance policy paying for services on an indemnity basis meeting these standards at $1,307 in 1988 (including all claims incurred and administrative expenses). Forty-two dollars of this total is for prenatal and well-baby care. This average cost is comprised of an individual cost we estimate at $708 annually and a family cost of $1,798. The cost is estimated over all employees of small employers and their dependents, excluding the self employed. Regional differences in the cost of medical care could cause these estimates to vary by 25% if census regions are used.

Comparisons with estimates by private insurers

There are a number of conceptual and practical differences between the average premium rates calculated by ARC and the premium rates that an insurance company would be expected to offer a particular small employer.

- Objective

The primary objective of the estimates was to serve as the basis for an economic analysis of the bill conducted by the CBO. Consequently it was important that the estimates reflect the long term economic consequences of the proposal, rather than any transitory effects. For this reason, premium rates were estimated to include allowances for profit and margins for uncertainty consistent with the long run experience of the industry, rather than an attempt to estimate the loadings that insurers would incorporate into their initial offerings for the pools.

- Payment Basis

Competition has led to a situation in which providers charge different prices to different patients and their insurers. This is especially the case for hospitals. Many of the Blue Cross plans in the East and Midwest have traditionally paid cost based reimbursements to hospitals that are well below charges. In recent years, many other insurers, especially HMOs and PPOs, have also negotiated special rates of payment.

The premium rates calculated by ARC reflect the average of all payers, not the charge level of hospitals or physicians. This is accomplished by controlling total hospital and physician payments in our national model to total National expenditures for these services as estimated by the Federal Government.

Premium rates calculated by insurance companies that have hospital and physician reimbursements on charges would be expected to estimate premium rates that are significantly higher than this overall average payment rate.

- Margins and Cost of Insurance

Since insurance companies are at risk, premium rates must include a margin to protect them against unexpected adverse developments (e.g., a higher inflationary trend, epidemics, adverse fluctuations in catastrophic claims, adverse selection, etc.). Actuaries of private insurance companies react to uncertainties by using "conservative" (i.e., higher) assumptions for price and utilization levels and inflation assumptions. In addition health insurers typically add as much as 5% to 10% "risk charge" to their rates for smaller groups.

Some margins would also be expected to be included in the rates offered in the small employer pools. But the amount would be restricted by two factors: competition and experience rating. Concerning the former, the conditions of the competition would tend to force insurers to minimize the margins for risk and/or profit. As to the latter, we have assumed that the Government would require that profits beyond a modest level would be used to reduce future premiums, as is done in the Federal Employees Health Benefits program.

The estimates prepared by ARC are based on an estimated average risk charge over the long run, not necessarily that which would be charged in the first year.

- Anti-selection

Some insurers, primarily the Blue Cross and Blue Shield Plans, provide a service to small employers by offering health insurance with few or minimal underwriting requirements. In many cases the rates are subsidized by risk charges to larger employers made feasible by hospital discounts and tax advantages. These Blue Cross Plans in effect offer pools that are open to all or most employers despite a higher level of risk and cost. Consequently, premiums based on Blue Cross and Blue Shield experience will be higher than the average cost for all employers.

- Shift Bias

An important factor influencing the insurance offered by employers is the coverage available to their workers from other employers. Many employers are currently changing their plans to encourage their employees to obtain their coverage from another employer.

Small employers are in a much better position to take advantage of shifting opportunities. This is frequently accomplished by offering other benefits or financial rewards in lieu of health coverage, removing the persons entirely from the covered group. A side-effect of removing employees from the covered group is to reduce the savings obtained through the coordination of benefits ("COB" savings).

Under the proposal, such shifting would be reduced. Each employer must cover its own employees. Consequently, COB savings will be increased, reducing the premium rate compared to the present situation.

SENATOR HATCH'S QUESTIONS FOR MR. TRAPNELL

1. MR. TRAPNELL, DO YOU BELIEVE THAT AN INSURANCE COMPANY WILL ACTUALLY UNDERWRITE A POLICY AS REQUIRED UNDER S. 1265 FOR $642 FOR A SINGLE AND $1631 FOR A FAMILY BENEFIT? PUT ANOTHER WAY, WARE YOU AWARE OF ANY COMPANY WHICH HAS ANNOUNCED IT CAN OFFER THESE PREMIUMS, BECAUSE THEY ARE ALL TELLING ME THAT THE PRICE OF THE POLICY WOULD BE 30 PERCENT HIGHER.

2. AS I UNDERSTAND YOUR COST ESTIMATE, YOU CALCULATED THE NUMBER OF UNINSURED WORKERS AND MULTIPLIED IT BY A COMPOSITE COST OF THE HEALTH INSURANCE PREMIUM.

   ACCORDING TO MY CHART, THE MEDIUM COST FOR AN INDIVIDUAL WHO HAS HEALTH INSURANCE IS ROUGHLY $833 IN 1985 DOLLARS. UNDER YOUR ANALYSIS, THE COMPOSITE PREMIUM WILL BE $1181. SINCE THERE ARE CURRENTLY MANY WORKERS WHOSE HEALTH INSURANCE PREMIUMS WILL INCREASE BY $300 OR MORE IF S. 1265 IS ENACTED, DID YOU INCLUDE THESE ADDITIONAL COSTS IN YOUR ESTIMATES?

Gordon Trapnell

RESPONSE TO QUESTIONS BY SENATOR HATCH

1. There are several crucial differences between our estimates of the average premium rates that would be paid for health insurance by small employers purchasing insurance from the regional pools and premium estimates supplied by the member companies of the Health Insurance Association of America (HIAA). We understand that 27 of the member companies supplied estimates of the average benefits and premium rates for single employees and families that would be charged to small employers for the minimum required benefits in high and low cost areas. We also understand that the average premium rate submitted is 30% higher than our estimated average premium for the small employer pool, and that approximately half of the difference is in the estimate of the average benefits that would be paid and half in the estimate of administrative costs. As I noted in my testimony. I have raised my estimates by 10.25% to recognize the higher inflationary trends that have become evident since I prepared my estimates, thus closing the gap for the benefits portion of the premium rates to around a 5% difference. Different estimates of administrative costs, however. account for around a 15% difference.

As noted in my testimony, there are a number of differences between the conditions under which the regional pools would operate and how insurance companies operate in today's market for small employer plans. One of these relates to the average rate of payment for hospital services. For example, all of the estimates by the insurers are apparently based on paying full hospital charges. But since the pools would include HMOs, PPOs and Blue Cross Plans that have negotiated substantial discounts from hospitals, the average payment rate to hospitals should be less than charges.

The most important difference, however, is presented by the structured competition to become one of the plans offered and for employers in open enrollments if successful. The regional pools would present an unprecedented business problem and opportunity for the health insurance underwriters. The situation is much more like the Federal Employees Health Benefits Program than it is like the plans offered now to small employers. (In fact the competitive pressures would be much more severe than in the FEHBP, where there is no annual competition to determine which insurers may offer plans.) The insurance companies interested in participating would go through a process of developing and pricing a product that is totally unlike that for any product they now market. This would involve a thorough examination of all aspects of the product to be offered, including pricing, and would be expected to lead to very different products than are now offered to small employers.

The size of the market being created is such that competition would be extraordinarily intense first to become one of the plans included and then to attract a substantial proportion of the employers. Further, since the choice of plan will be made by employers all of whom have in common that they are unwilling or unable to pay for a health plan at present, the insurers will be keenly aware that price will be the primary factor leading to market share, and will bid accordingly.

It is our belief that comparisons between the projected outcome of a process like that set in motion by the regional pools and the off the shelf premium estimates charged under an entirely different set of marketing and administrative circumstances are invalid. This is particularly the case for the administrative costs and allowances for "risk charges" by insurers cutting costs to meet intense competitive pressures. Further, it is not the average cost of all insurers that will determine the premium rates of plans in the pools, but the lowest cost offerers.

2. Estimates of the impact of upgrading present coverage to meet the standards in the Bill were prepared by the CBO. It is our understanding that very few plans would be affected by upgrades. Existing plans are permitted to qualify on the basis of different benefit packages and cost sharing provided that the average cost of the plan is "actuarially equivalent" to the estimated average premium rate for minimum coverage.

The CHAIRMAN. Mr. Robbins?

Mr. ROBBINS. Thank you, Mr. Chairman.

My name is Gary Robbins, and I am President of Fiscal Associates, Incorporated, an economic research and consulting firm. My wife and co-author is joining me this morning.

Before joining the private sector, I served 16 years with the Treasury Department in various capacities, including Chief of the Applied Econometrics Staff, Special Assistant to the Undersecretary for Tax and Economic Affairs, and Assistant to the Director of the Office of Tax Analysis.

I am currently participating in an ongoing project for the Institute for Research on the Economics of Taxation to examine the economic implications of alternative ways to finance health care. IRET is a nonprofit 501(c)(3) public policy research organization. As part of this project, we prepared an economic analysis of the Minimum Health Benefits for All Workers Act of 1987, S. 1265. I would like to summarize briefly my testimony for the Committee.

Mandatory health insurance must increase payroll costs and ultimately reduce employment.

We estimate that S. 1265 would raise costs initially by $100 billion, resulting in 1 million fewer jobs and $25 billion less in GNP.

The increased labor costs of American workers relative to foreign workers would adversely affect our world trade position.

The burden of these increased payroll costs would fall with differing weights among the employees and businesses in different sectors of our economy. It would fall more heavily on those in the labor-intensive sectors of the economy. Employees of small businesses would be affected more than those of large businesses. Low-productivity, low-wage workers would find the insurance costs represent a larger portion of their total pay package.

The bill would distort the pay packages of many U.S. workers and leave workers worse off.

The bill would raise the cost of health insurance, not reduce it. The increased coverage would increase the demand for medical services, leading to higher medical costs.

Mandatory health insurance described in S. 1265 would reduce Federal tax revenues from between $9 billion, using our method and the Chairman's cost estimates, and $35 billion based on our cost estimates.

The major difference between the estimates that Mr. Trapnell has provided of the premium and our estimates derive from data contained in the National Income and Product Accounts, which are based on actual employer contributions for health insurance premiums. Those, when you do the arithmetic, are about 25 percent higher than the estimates used by the Committee staff for the minimum package.

Further, survey data indicate that many existing employer-provided plans would not meet the minimums specified in S. 1265. Because the premiums for existing plans are 25 percent higher than that given in the minimum package, we estimate that the cost of the minimum package would similarly be 25 percent higher. This would mean higher premiums for those with existing coverage. In other words, the minimum package may not be that at all.

In the short run, half the total $100 billion cost results from the provision that requires every two-earner family to purchase two separate, rather than one family, policy. Over time, this cost would disappear as insurance companies gained experience in pricing the new policies.

However, over the long run, the fixed $250 deductible would raise the cost of the premiums faster than the rate of medical insurance. In 10 years, for instance, a $250 deductible would be equivalent to a $100 deductible today.

Finally, the Government franchise provisions contained in S. 1265 would decrease competition in the medical insurance industry and also lead to higher costs.

What we urge in our report that we are submitting today is a less expensive approach to the problem of increasing the proportion of workers with health insurance coverage, and what we suggest is to remove the restrictive regulations on employer-provided insurance benefits at the Federal and State and local levels.

I offer my prepared remarks and a copy of our study for the record and would be glad to answer any questions.

Thank you.

[The prepared statement of Mr. Robbins and responses to questions submitted by Senater Hatch follow:]

"ECONOMIC CONSEQUENCES OF THE MINIMUM HEALTH BENEFITS FOR ALL WORKERS ACT OF 1987 (S. 1625)"

Testimony presented to

THE U.S. SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

by

GARY A. ROBBINS *

PRESIDENT, FISCAL ASSOCIATES, INC.

on behalf of

THE INSTITUTE FOR RESEARCH ON THE ECONOMICS OF TAXATION (IRET)

November 4, 1987

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* The views expressed here are my own and do not necessarily reflect the views of IRET or its contributors.

"ECONOMIC CONSEQUENCES OF THE MINIMUM HEALTH BENEFITS FOR ALL WORKERS ACT OF 1987 (S. 1625)"

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Oral Summary

- Mandatory health insurance must increase payroll costs and ultimately reduce employment.
    - We estimate that S. 1265 would raise costs initially by $100 billion, resulting in one million fewer jobs and $25 billion less in GNP.
    - The increased labor costs of American workers relative to foreign workers would adversely affect our world trade position.
- The burden of these increased payroll costs would fall with differing weight among employees and businesses.
    - It would fall more heavily on those in the labor intensive sectors of the economy.
    - Employees of small business would be affected more than those of large businesses.
    - Low productivity (low wage) workers would find the insurance costs represent a larger portion of their total pay.
- The bill would distort the pay packages of many U.S. workers and leave workers worse off.
- The bill would raise the cost of health insurance, not reduce it. The increased coverage would increase the demand for medical services, leading to higher medical costs.

- Mandatory health insurance described in S. 1265 would reduce federal tax revenues from between $9 billion, using the cost estimates provided by Senatory Kennedy, and $35 billion, based on our cost estimates, in 1988.

- Based upon National Income and Product Account data on actual employer contributions, health premiums for existing employer-provided plans are 25 percent higher than the estimates given for the minimum package.

- Survey data indicate that many existing employer-provided plans would not meet the minimum specified in S. 1265. Because the premiums for existing plans are 25 percent higher than that given for the minimum package, we estimate that the costs of the minimum package would similarly be higher by 25 percent.

- This would mean higher premiums for those with existing coverage. In other words, the minimum package may not be that at all.

- In the short run, half of the total $100 billion cost results from the provision that requires every two-earner family to purchase two separate, rather than one family, policies. Over time this cost would disappear, as insurance companies gain experience in pricing the new policies.

- Over the long run, the fixed $250 deductible would raise the cost of premiums faster than the rate of medical inflation. In ten years, a $250 deductible would be equivalent to a $100 deductible today.

- Finally, the government franchise provisions contained in S. 1265 would decrease competition in the medical insurance industry and lead to higher costs.

- A less expensive approach to the problem of increasing the proportion of workers with insurance coverage would be to remove the restrictive regulations on employer-provided insurance benefits at the federal and state levels.

"ECONOMIC CONSEQUENCES OF THE MINIMUM HEALTH BENEFITS FOR ALL WORKERS ACT OF 1987 (S. 1625)"

Testimony presented to

THE U.S. SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
by
GARY A. ROBBINS
PRESIDENT, FISCAL ASSOCIATES, INC.
on behalf of
THE INSTITUTE FOR RESEARCH ON THE ECONOMICS OF TAXATION (IRET)
November 4, 1987

Mr. Chairman and Members of the Committee, I am Gary A. Robbins, President of Fiscal Associates, Inc., an economic research and consulting firm. Before joining the private sector, I served 16 years with the Treasury Department in various capacities, including Chief of the Office of Applied Econometrics, Special Assistant to the Under Secretary for Tax and Economic Affairs, and Assistant to the Director of the Office of Tax Analysis.

Currently I am participating in an on-going project for the Institute for Research on the Economics of Taxation (IRET) to examine the economic implications of alternative ways to finance health care. IRET is a non-profit 501 (C)(3) public policy research organization. As part of this project, we prepared an economic analysis of the "Minimum Health Benefits for All Workers Act of 1987" (S. 1265). I am pleased to summarize for the Committee the major findings of our study.

The primary impetus behind the approach taken in the bill introduced by Senator Kennedy is concern for the 35 to 40 million

Americans that do not have health insurance. This situation certainly deserves our attention.

What also merits attention, however, are the economic consequences that the proposed solution, mandatory employer-provided health insurance, or any other proposed solution, would have. These consequences could have negative effects on the lives of both insured and uninsured persons and adversely influence the development of our economy over time. We believe that these concerns must also be a vital part of any health policy deliberation.

Economic Consequences for Workers and Employers

Mandatory health insurance would require a major change in labor compensation practices. The federal government, in effect, would be telling a worker that a specific part of his or her earnings must be spent on health insurance, leaving less for food, housing, clothing, education, pensions, and so forth.

The amount of labor compensation a person receives is determined by the value of his or her product. The pay package includes employment taxes, such as social security and unemployment compensation, fringe benefits, such as pensions and health insurance, and money wages. Labor compensation increases only if the value of a worker's product increases. There is nothing inherent in a mandated health insurance package that, in and of itself, would increase productivity or make consumers willing to pay higher prices for the same product they had been buying at lower prices. The costs of mandated health insurance would have to come out of this same pay package.

Compliance with S. 1265 would increase health insurance costs. Because there would be no offsetting increase in labor compensation to pay for those higher health insurance costs, this would lead to a reallocation of the labor compensation package away from money wages and other fringes and toward health insurance. The initial effect, before pay packages can be adjusted, will be to increase payroll costs. Some workers will lose their jobs. Other members of the labor force that would have been hired, won't be. The extent of the reallocation depends upon how much the mandatory health insurance package would raise health insurance costs over what they would be in the absence of the mandate.

The Increase in Health Insurance Costs

The increase in health insurance costs would depend upon:

- The cost of the mandatory minimum health insurance package, or the premium.
- The extent to which the mandated package exceeds the cost of currently provided employer health insurance.
- At least initially, the increase in premium costs due to the multiple policies in families with more than one worker.
- Additional administrative costs.

The cost of mandatory minimum health insurance and its economic effects depend upon the premium charged. This premium won't be known until insurance companies actually market that specific product. We examined information about the current employer-provided health insurance market in an effort to obtain some idea of what that premium might be.

First, we looked at National Income and Product Accounts data, which are based on tax return records, to find out how much is currently spent per covered employee. Employer contributions to health insurance totaled $105 billion for 90 million insured workers in 1985. This was an average employer expense of $1,161 per insured worker.

Three years of medical inflation would drive premiums up unless there were offsetting reductions in coverage. For instance, 20 percent medical inflation between 1985 and 1988 would lead to a 20 percent increase in covered medical costs. The deductible and copayment amounts determine the proportion of covered medical services paid by the individual or insurer. Keeping the copayment rate constant, the deductible must increase with the rate of medical inflation in order to maintain the same split between individual and insurer. If deductibles were raised by the 20 percent assumed medical inflation, the average employer contribution in 1988 would be about $1,400.

Next, we looked at estimates that Chairman Kennedy offered in the Congressional Record. The projected average employer contribution for the mandated minimum health benefit package in 1988 is $1,186, or 15 percent less than the $1,400 projected from NIPA data. Another adjustment must be made to the NIPA figure, however, because S. 1265 would require that employers pay at least 80 percent of the premiums for single and family coverage. This would represent an 8 percent increase over current practices and increase the $1,400 estimate to $1,512.[1] It is difficult to explain why the per employee cost of the mandated minimum package would be less than that estimated for present health insurance unless the mandated insurance provides less in benefits or has more stringent coverage requirements.

Because the estimated cost of the mandated minimum package is about 25 percent less than the projected average employer contribution based on tax return data, we then looked to see if there was any information about the type of benefits currently provided. For example, a recent survey indicates that, in 1986, 17 percent of employer plans did not provide coverage for physician office visits and 13 percent did not cover prescription drugs. The average 1986 deductible was about $230, and the annual average premium for a single worker was $1,020.[2] This premium is also consistent with the aggregate employer contributions figures from NIPA. (Since last June when we prepared our estimates, another survey of 70 firms indicates that none of the employers would meet all the provisions of the minimum package with their current insurance.)[3]

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[1] Information from a survey conducted by the Small Business Administration indicates that employers currently pay 86 percent of single worker premiums and 71 percent of family premiums. Family premiums are up to 2.5 times more expensive than single worker premiums.

[2] ICF Incorporated, Health Care Coverage and Costs in Small and Large Businesses: Final Report, Prepared for the U.S. Small Business Administration, April 15, 1987, Tables IV-4, IV-7, and B-3.

In order to keep premiums from going up by more than the rate of medical inflation, deductible amounts must rise by that same rate. Based on our estimate that medical inflation will increase by 14 percent from 1986 to 1988, the average 1986 deductible of $230 would have to increase to $262 to keep the 1986 average premium of $1,020 from increasing to more than $1,162.[4] Because the bill would require a $250 deductible amount in 1988, our "best guess" is that the single worker premium for the minimum package could be on the order of $1,200 in 1988 and an average employer contribution per worker, weighted by family composition, of $1,600. In other words, our assessment of market information suggests a minimum package premium that is 25 percent higher than the original estimate.

Based upon the higher premium, we estimate that the cost of employer-provided health insurance would increase by $100 billion in 1988. Table 1 shows the cost for four of the major components and designates whether it would be assigned to employers or employees. As mentioned earlier, the cost of health insurance must come out of the employee's pay package. The assignment to employer or employee, however, does have implications for federal tax revenues, as I will discuss later.

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[3] The findings of a survey by Towers, Perrin, Forster & Crosby are reported in Geisel, Jerry, "Health Plans Fail Mandate: Survey," Business Insurance, August 31, 1987.

[4] The administration's 1988 budget provides an excellent example of how insurance premiums go up faster than the rate of medical inflation when nominal deductible amounts are fixed. The 1988 budget anticipates a 30 percent increase in the premiums for federal employees between 1986 and 1988, even though medical inflation likely will be more on the order of 14 percent.

Table 1

Increase in 1988 Health Insurance Costs (in Billions)

Coverage	New	Existing	Mandatory Duplication	Additional Administrative Cost
EMPLOYERS	$29.5	$21.1	$36.0	$2.0
EMPLOYEES	7.4	(4.8)	9.0	
TOTAL	$36.9	$16.3	$45.0	$2.0

TOTAL INSURANCE COST INCREASE $100.2 billion

Table 1 shows that there would be an increase of $37 billion in health insurance costs for the 18.5 million workers projected to be without health insurance in 1988.[5] There would be an increase of $16.3 billion in health insurance costs for workers with existing coverage.

In the short run, almost half of the total cost results from the provision that requires every two-earner family to purchase two separate, rather than one family, policies. The cost of this mandatory duplication of coverage within families would be on the order of $45 billion. Duplicate coverage would eventually disappear if insurance companies were allowed to develop a new product that specifically addresses the overlap. For example, would a worker have to satisfy the $250 deductible if the $500 family deductible had already been met? This development process, however, would take time for the insurance companies to gain experience about family health care utilization patterns under the bill.

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[5] The number of uninsured workers was projected to 1988 by multiplying the ratio of uninsured workers to total employment in 1985 times total employment forecasted for 1988. Applying the projected 18.5 million uninsured workers to the original $1,186 estimate for employer contributions cited by Senator Kennedy would bring the cost for uninsured workers to $27.4 billion.

Macroeconomic Effects

The increase in health insurance costs would be paid by employers initially because the total pay package could not be changed instantaneously. This increase in payroll costs would mean a reduction in employment, at least compared to levels that otherwise would have been attained. In time, the pay package would be redesigned although total compensation would still have to equal the value of workers' product. The redesigned pay package would have less cash wages and other fringe benefits and more health insurance than otherwise would have been. The net result would not be uniform for all employees because it depends upon the type of health insurance different employees would have chosen in the absence of the mandate.

Because there would be no change in the value of labor's product, the $100 billion increase in health insurance costs would lead to one of two outcomes:

- Other labor compensation -- namely money wages, pensions, and other fringe benefits -- would be reduced. This is the same as increasing the tax on labor compensation by 1.75 percent.

- Some employers will reduce employment below what it otherwise would have been. This could be an actual reduction in the work force or a slowing in hiring new workers.

The net result of a $100 billion increase in employer-provided health insurance costs would be a million fewer jobs in the economy than would otherwise occur. Fewer jobs mean less labor services and less output. One million fewer jobs would result in $25 billion a year less total real output in the economy.

These economic effects would intensify over time due to the increasing costs of the mandated minimum health insurance program. As medical inflation increases, the costs of a fixed $250 deductible will increase geometrically. Furthermore, as medical services become more and more expensive relative to other goods, workers and their families would try to economize on health care to provide more funds for other things, like food and shelter. The mandated minimum package, however, requires that they purchase specific coverage which will require an ever increasing share of their wages. This, in effect, is an ever increasing tax that makes work seem less and less desirable, leading to a reduction in labor supply and therefore even less employment.

Federal Revenue Consequences

A Federal tax loss would occur due to the reduction in the income and social security tax bases. Wages currently received by the employee, and therefore taxable, would be taken instead in the form of employer insurance contributions. The social security tax base would be reduced by the sum of all four categories of increased employer contributions, or $88.6 billion in 1988. The revenue loss of $13.3 billion is the reduction in the tax base times the 15.02 percent combined employer-employee social security tax rate in 1988.

The income tax base would be reduced by somewhat less because not all workers would have paid income taxes on wages which would now pay for health insurance. We assume that one-half the new employer contributions and one-half the added administrative costs would fall into that category, resulting in a $72.8 billion lower income tax base. Given an average marginal tax rate on wage and salary income of 23 percent in 1988 under current tax law, the reduction in federal income taxes would be $16.7 billion.[6]

The combination of lower income and payroll taxes would be $30 billion in 1988. This is a static revenue loss estimate because it does not take into account any changes, such as a reduction in employment, that would result from the bill. An additional $5 billion revenue loss would result from the dynamic adjustments in the economy due to the reduction in aftertax labor compensation.

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[6] The estimate of the average marginal tax rate comes from the Fiscal Associates' Individual Tax Model which uses individual tax return data from 1984 extrapolated to 1988. The economy-wide average is weighted with wage and salary incomes. The 23 percent rate implies that more wages will be taxed at the 28 percent rate than at either the zero or 15 percent rates.

Table 2

1988 Federal Tax Loss (in Billions)

	Tax Base	Rate	Revenue Loss
SOCIAL SECURITY	$88.6	15%	$13.3
INCOME	72.8	23%	16.7
STATIC FEDERAL REVENUE LOSS			$30.0
REVENUE LOSS DUE TO ECONOMIC EFFECTS			5.0
TOTAL FEDERAL REVENUE LOSS			$35.0

Using the premium estimate supplied by Chairman Kennedy, there would be a $9 billion reduction in federal tax revenues due to a loss of $30 billion in taxable base. There would be a reduction of $21 billion in taxable base due to the employer contributions for currently uninsured workers. The increased contribution rate for family coverage in existing plans would lead to a tax base decrease of $9 billion.

Other Concerns

There are other features of the bill that would have economic consequences. Although we have not made quantitative estimates, the potential effects should be noted.

To the extent that increased coverage leads to increased health care utilization, medical inflation will rise. Since 1948, about 50 cents of every additional dollar allocated to medical expenditures ends up as an increase in medical prices, not medical services. An acceleration in medical inflation will mean higher premiums for the mandated package, for other private health insurance, and higher Medicare and Medicaid expenditures.

Limiting choices to employers and employees through a minimum benefit package also limits the ability of insurance companies to compete and to lower costs, or at least to moderate future increases. The proposed system of regional insurers establishes the government, specifically the Department of Health and Human Services, as a distributor of monopoly rights to a few insurance companies. As with any monopoly situation, this creates the problem of extraordinary profits and the need for rigorous scrutiny over the bidding process.

The ban on pre-existing condition restrictions could have undesirable effects on some people. While S. 1265 would mandate that an employee with a pre-existing condition could not be denied coverage, it does not mandate that the employee be hired.

Other Ways to Promote Health Insurance Coverage

My remarks so far have focused on the costs of the proposed minimum benefit package. Another consideration, however, is whether there may be better ways to address the problem of the uninsured. The attached shows the percent of the population covered by private hospital insurance and physician expense insurance from 1960 to 1984.[7] In 1960, about 69 percent of the population was covered by private hospital insurance and 46 percent for physician expenses. In 1984, 79 percent of the population was covered by hospital insurance and about 73 percent for physician expenses. As the graph shows, this trend has been basically stymied, drifting sideways and downward from a peak of 83 percent in 1978 for hospital insurance and a peak of 78 percent for physician expenses.

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[7] U.S. Department of Commerce, Bureau of the Census, Statistical Abstract of the United States, 1987, Table No. 137, p. 89. Most private insurance comes from employer-provided

Is there something inherent in the marketplace that has caused the growth in health insurance coverage to stagnate? Are the profit motives of employers causing them not to provide health insurance? If profit is the motive, employers would do their best to pay their employees with the cheapest possible dollars. They would want, therefore, to provide as much tax-favored fringe benefits, such as health insurance, as their employees would be willing to accept.

Because some employers don't, there must be other factors at work. One might be governmental rules and regulations covering employer-provided benefits. Is it coincidental or causal that the downward trend in health insurance begins shortly after passage of the Employment Income Security Act of 1974 (ERISA)? The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Deficit Reduction Act of 1984 (DEFRA), and particularly the Consolidated Budget Reconciliation Act of 1986 (COBRA) further complicated the provision of employee benefits. The states have

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plans. In 1985, employer contributions alone accounted for $105 billion out of $133 billion spent on private insurance. (See the Health Care Financing Review, Fall 1986, Table 3, p.15.)

also added to the trend of increased regulation by mandating the content of employer-provided plans.

The impact of these regulations affect firms and industries unevenly. For example, the non-discriminatory provisions of ERISA require employers to provide equal coverage to all employees. For firms that experience a high turnover in a portion of their labor force, the administrative costs associated with this turnover raise the costs of health insurance above the benefits of their tax-free status. The cost of regulation falls more heavily on small business because it is less likely to have the administrative machinery in-house. Not surprisingly, small business has lower health insurance coverage. It has also provided much of the employment growth during this economic expansion.

Another causal factor are tax laws. The self-employed account for 13 percent of employment and 27 percent of the uninsured. Before the Tax Reform Act of 1986, self-employed persons did not receive tax-favored treatment for health insurance. Last year's tax reform allows them to deduct 25 percent of their health premiums. Senator Kennedy, recognizing this problem, has introduced a companion bill that would correct it. This is the very kind of change that would increase the proportion of covered workers by making health insurance more affordable.

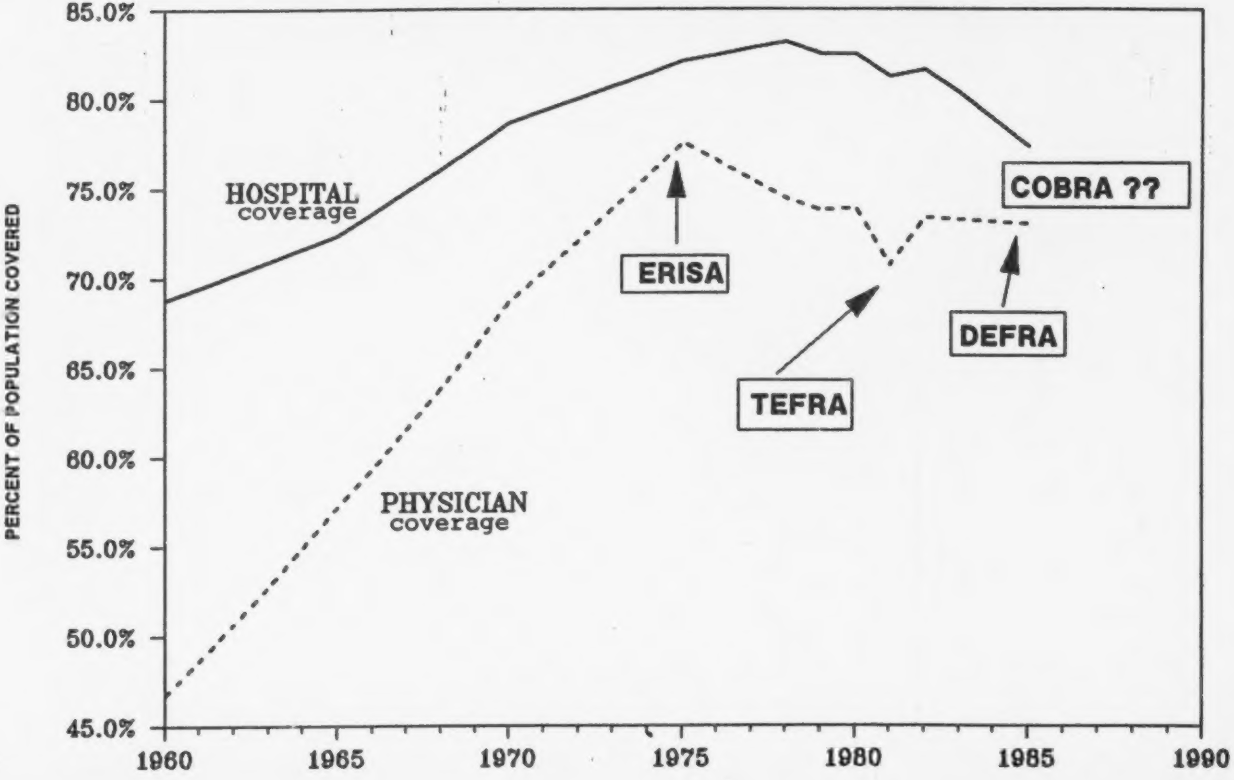
Further, the general thrust of tax policy over the last 15 years has been to increase the tax on capital and therefore on heavy industry. The decline of the smokestack industry is due less to foreign competition and more to tax policy. In other words, tax laws have helped promote the growth of the service sector, which happens to be the one with a lower degree of health coverage.

Conclusions

In conclusion, S. 1265 would have serious economic consequences. It would:

- o Increase payroll costs and ultimately reduce employment,
- o Increase labor costs of American workers relative to foreign workers and adversely affect our world trade position,
- o Distort the pay packages of many U.S. workers, and
- o Reduce federal tax revenues from between $9 billion and $35 billion in 1988.

The Committee's concern for the increasing number of uninsured workers is to be commended. I believe, however, that a close examination of the trends in coverage suggest a different approach to the problem. The rapid increase in coverage through the 1950s, '60s, and the first half of the 70s already indicate the willingness of employers to provide health coverage. The increasing level of regulation, not avarice, is the culprit. I suggest that a more effective method of increasing health coverage is to reverse the legislative restrictions and allow employers and employees to find the most effective means of providing the coverage which best suits their needs. The natural forces which worked in the 1960s would reverse the trend once again.



TRENDS IN PRIVATE HEALTH INSURANCE

COVERAGE RATES FOR HOSPITAL AND PHYSICIAN EXPENSES

RESPONSE TO QUESTIONS OF SENATOR HATCH

by

Gary A. Robbins
Fiscal Associates, Inc.

Question 1: Mr. Robbins, you note that a less expensive approach to the problem of uninsured workers might lie in removing restrictions on employer-provided insurance benefits. Could you explain how these restrictions currently hinder access?

Government regulations of employer-provided benefit plans, including health insurance, over the last decade or so have increasingly required specific administrative procedures, called for additional paperwork, and imposed costly penalties for non-compliance. For example, COBRA requires that employer-provided benefit plans must comply with the following provisions:

- the plan must be written,
- employee rights under the plan must be legally enforceable,
- employees must be given reasonable notice of benefits available under the plan,
- the plan must be maintained for the exclusive benefit of employees,
- the plan must be set up with the intent that it be maintained indefinitely, and

- if a plan fails to comply with these requirements, employers must report separately on employees Form W-2 the amount of benefits an employee is required to include in gross income. Employers failing to report are subject to a penalty tax that is equal to the unreported benefit amount times the highest individual tax rate for that taxable year.

The purpose of these kind of regulations is to assure that the benefits are uniformly conferred on all workers. The result however, can be that plans disappear and no benefits are provided because seemingly simple requirements can add significant administrative costs and complexity to a benefit plan.

Compliance requires assistance from accountants, lawyers, and other employee benefit technical experts. The penalties can be so severe, disqualifying the entire plan for tax-favored status, that the risk associated with providing a plan becomes increasingly great. The risk of not maintaining the appropriate paperwork requirements is magnified for firms with high turnover. At some point, the cost of complying with these requirements increases the cost of insurance beyond what employers and employees think it's worth. This point is often reached sooner with a small business.

Question 2: Mr. Robbins, you have noted that health care cost inflation is much higher than general inflation. Have you any estimates on what impact S. 1265 will have on health care costs and who will pay these additional costs?

The increase in medical inflation will depend upon how much additional health expenditures result from the increased health insurance coverage. Regression analysis over the period 1948 to 1986 shows that approximately 50 cents of every additional dollar allocated to medical expenditures ends up as an increase in medical prices. For instance, if actual medical expenditures increase by $15 billion as a result of S. 1265, one would expect $7.5 billion to be dissipated by price increases. At current levels of medical expenditures (about $500 billion), this would mean a permanent increase of 1.5 percentage points in the medical deflator.

Our research indicates that a scalar multiple can be used to estimate the increase in medical inflation that results from larger or smaller changes around $15 billion. For example, if medical expenditures increase by $30 billion, medical prices would increase by 3 percentage points.

The added costs of medical inflation would be borne by all who pay for medical care. In 1985, the public sector paid 40 percent of all medical expenses. The $7.5 billion increase in prices due to an additional $15 billion in medical expenditures would add $3 billion to public spending on medical care

($2.25 billion of which would occur at the federal level). In 1985, private insurance paid 30 percent of medical expenses. Medical inflation would add $2.3 billion to the cost of private health insurance. Individuals, who paid almost 30 percent of medical expenses out-of-pocket, would pay an additional $2.2 billion. Because the increase in medical inflation depends upon the increase in medical demand, offsetting savings to government and private insurers will ultimately depend upon how much additional medical expenditures and medical inflation result from S. 1265.

Question 3: I have the impression that, despite the high cost of S. 1265 to employees (and initially to employers), adjustments in the hiring patterns in the economy will still leave many persons without coverage. Have you any idea of the size of this remaining group?

According to Census data, about one-third of the uninsured would not gain coverage under S. 1265. Current estimates of the number of uninsured range from 35 to 40 million people. Thus, between 12 and 13 million people would remain uninsured. In addition, the reduced employment that would result from S. 1265 must also be taken into account. The employment effect depends upon how much the bill will actually cost, and estimates range from 100,000 fewer jobs to as many as a million. Taking into account the dependents of these workers, there could be an additional 200,000 to 2 million uninsured persons.

The CHAIRMAN. Let me ask you, Mr. Robbins, do you know why all of the other econometric CBO estimates are relatively within the same ball park with the exception of yours? Does that cause you any concern at all?

Mr. ROBBINS. The only real difference between the econometric studies that were talking about the labor impact and the study that we did was that we were using a higher premium. And once you have cranked in the higher premium, the overall cost in the economy is substantially higher, and as a result, the employment cost.

If I were to use the cost estimates provided by the Committee, our employment effects would be minuscule, also.

The CHAIRMAN. So it is basically the differences in terms of the premium, is that it?

Mr. ROBBINS. Yes, sir, that is correct.

The CHAIRMAN. Now, I understand that the MHB Minimum Plan—the Labor Department surveyed the benefits in firms with 50 or more workers, and they say 70 percent of insured workers are covered by plans that provide coverage for care in extended care facilities.

Does our plan provide for coverage in extended care facilities?

Mr. ROBBINS. No, it does not.

The CHAIRMAN. Ninety-seven percent are covered for prescription drugs. Does our plan provide for coverage for prescription drugs?

Mr. ROBBINS. I do not believe so.

The CHAIRMAN. Sixty-six percent are covered for home health care. Does our plan provide for home health care?

Mr. ROBBINS. I think in small part. Let me see——

The CHAIRMAN. The answer is "no", unless something got in there overnight.

Seventy-one percent are covered for dental care. Does our plan provide for coverage of dental care?

Mr. ROBBINS. No, sir.

The CHAIRMAN. Seventy-four percent are covered by a plan with a deductible of $200 or less, and 58 percent are covered by a deductible of $100 or less. The level of the deductible has a tremendous impact on the cost of a plan. I take it that you are aware the deductible of our plan is $250.

Mr. ROBBINS. Yes, sir.

The CHAIRMAN. Another survey of large and small firms done for small business found that 70 percent had out-of-pocket stop-loss provisions of $2,000 or less. Do you know what the out-of-pocket stop-loss level of our plan is?

Mr. ROBBINS. Three thousand.

The CHAIRMAN. So to try and estimate the plan cost by comparing it to an average plan in the economy does not seem to be a very reliable procedure.

Mr. ROBBINS. Well, I have looked at other sources. For instance——

The CHAIRMAN. Well, the one you quoted in the testimony is the one I just referred to. You indicated in your testimony that you looked at the MHB minimum plan.

Mr. ROBBINS. Yes, sir. And what I tried to do was to find an actual market price that reflected what the plan would cost, and I had difficulty finding that. It is true that the surveys that you are citing show that the benefits are somewhat less, and the costs are somewhat less, but those were all done in the past, and you have to extrapolate those somehow to 1988, because that is what you are trying to estimate.

I have here the cost of some 1988 plans.

The CHAIRMAN. Well, these are 1986; the one I have is 1986.

Mr. ROBBINS. Yes, that is right.

The CHAIRMAN. Well, it is 1987 now. I do not know what basis your methodology in extrapolating from 1986 to 1987 and coming up with——

Mr. ROBBINS. Well, for instance, the medical insurance premiums in the Government sector from 1987 to 1988 fiscal years jumped by 30 percent on average. So it would be substantial.

The CHAIRMAN. But that is medical inflation, not benefits.

Mr. ROBBINS. No, sir; those are in premiums. Now, let me give you an example——

The CHAIRMAN. Well, you do not claim that any of these benefits I have just referred to, that are by and large quite costly, have been stripped in the last year, are you?

Mr. ROBBINS. In some cases, they have been reduced, yes, sir.

The CHAIRMAN. Well, in which?

Mr. ROBBINS. In the case of the Governments plans which, as I said, we have an excellent description of in here, the benefits have been reduced in the plans, and the plans have still gone up by substantial amounts.

The CHAIRMAN. In which?

Mr. ROBBINS. Well, let me give you an example of the largest insurance plan in the country. It insures the largest number of employees in one single plan. That plan has a $250 deductible; it has an $8,000 cap, not $3,000; it pays——

The CHAIRMAN. Which plan is this?

Mr. ROBBINS. This is the Government Blue, basic, standard sell.

The CHAIRMAN. What is the stop-loss in it?

Mr. ROBBINS. Eight thousand dollars.

The CHAIRMAN. I do not believe you are right. A member of my staff has the plan——

Mr. ROBBINS. Well, I called them yesterday.

The CHAIRMAN [continuing]. and he says it is a $2,000 stop-loss——

Mr. ROBBINS. That may be on the high-option; on the standard, it is $8,000.

The CHAIRMAN. Well, we will have a chance to go through those in some detail. But as I understand, your principal basis of disagreement is on premium cost?

Mr. ROBBINS. Almost entirely.

The CHAIRMAN. Well, that's okay. We will get into that in greater detail.

We have some other questions which will probably be submitted. I would like to go back through it, but as Senator Quayle mentioned, there is an important Armed Services Committee meeting which I am already late for.

So we thank you all very, very much. I think it has been a helpful hearing.

[Additional material supplied for the record follows:]

75th ANNIVERSARY
1912 1987

U.S. CHAMBER OF COMMERCE

Albert D. Bourland
Vice President
Congressional Relations

November 4, 1987

The Honorable Edward M. Kennedy
Chairman
Committee on Labor and Human Resources
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The U.S. Chamber of Commerce testified on June 24, 1987 before the Committee on the Minimum Health Benefits for All Workers Act of 1987, S. 1265. At that time, the Chamber explained its concerns regarding the legislation and outlined four alternatives to mandates for addressing the problem of gaps in health care coverage. It again urges the committee to consider those alternatives--expansion of tax incentives for nonincorporated businesses, preemption of state mandated benefits, encouragement of multiple employer trusts and development of Medicaid buy-in arrangements--instead of moving forward with S. 1265. In brief, the Chamber's perspective is that if high cost is the main obstacle preventing more employers from offering health insurance, then pursuing means to provide less costly coverage, rather than requiring all employers to pay for expensive coverage, is the most viable option for meeting our mutual goal--expanded health care protection.

The Chamber has organized the "Coalition on Mandated Benefits." The coalition now numbers over 1,500 large and small companies, chambers of commerce and other organizations. As you will see from the attached list of members, the coalition includes some of the nation's largest employers as well as some very small entrepreneurs. The coalition members are opposed to Congressionally mandated benefits and urge you not to favorably report S. 1265.

Over the past several months, the Chamber has received copies of many letters sent to Senators and Representatives from businesses regarding S. 1265 and its companion bill, H.R. 2508. These business people are concerned about the effect of this legislation on their ability to stay in business and the ability of American companies, generally, to deal with foreign competition.

1615 H Street, N.W. □ Washington, D.C. 20062 □ 202/463-5600

Since the topic of today's hearing is the impact of mandated health benefits, the Chamber wishes to provide for the official hearing record excerpts from some of these letters, which are attached.

The Chamber requests that this letter and its attachments be included in the hearing record.

Sincerely,

Albert D. Bourland

Attachments

cc: Members of the Committee on Labor and Human Resources
Thomas M. Rollins, Chief Counsel/Staff Director
Hayden G. Bryan, Minority Staff Director

Excerpts from Letters Regarding Mandated Health Benefits

I cannot begin to convey to you, the alarm our company is experiencing as a result of the news of Sen. Kennedy's mandated health insurance proposal. Our daycare center is only a year old. We employ about 20 people and value each of them highly. They are loyal to us and know that as our business grows and we get over the initial expenses of opening (about 3-4 years, hopefully) that we will pass along better wages and benefits as we are able.

Right now, we are not able. I dread to think what these new proposals (mandated insurance and the drastic raise in minimum wage) will do to our company. If we go under, 20 employees will no longer have a job and 175 children will be denied the quality educational environment we provide for them. How can anyone possibly think this is helpful?

Day care center, Waco, Texas

Despite the fact that my Company has one of the most liberal health care plans in the textile and apparel industry, we estimate that the proposed bill . . . . would add $7.1 million per year to our cost structure. For many small textile and apparel companies which are even now marginally profitable, these added costs would be proportionally greater and, potentially ruinous.

Textile manufacturer,
West Point, Georgia

Senator Kennedy's bill would eliminate 3 of the 7 jobs I now provide.

Hardware company,
Russellton, Pennsylvania

The imposition of such costs will certainly act as a disincentive to expand a company's workforce, and will also serve as an incentive to layoff current employees, especially for small businesses operating on a marginal profit. Mandating health benefits, therefore, would contribute to unemployment, and consequently would actually increase the number of uninsured, contrary to legislative intent.

3,200 member national trade association,
Chicago, Illinois

We are in the fresh fruit packing business and are thus in the industry of agriculture which at best can be described as on the brink of disaster. We are very seasonal, employing 120 or so people for about six weeks, 20 or so for about six months and 10 or so the balance of the year. Our turnover rate is extremely high, and very few of the persons employed in one season return for the next season. For obvious reasons, it would simply be financially impossible for us to provide health insurance for the type of employment scenario described above.

Fruit packing company,
Hamilton City, California

As of May 1, 1987, my group premium increased a minimal amount of $12.00 for single coverage, but the family coverage increased by $56.00. Based on these rates it would cost me $1,916 annually per employee for the 80% government mandated coverage. I am currently paying $840 per employee for single coverage. You can see that this represents an increase of over $1,000 per employee in overhead to my company.

Property management company
Topeka, Kansas

The mandated benefits legislation will not be good for jobs or for the rate of inflation here in Ohio, particularly among the small businesses that have very limited (if any) reserves after taxes to use in purchasing production equipment and financing efforts to increase sales.

Medical service company, Akron, Ohio

Should this act ever pass, I can only tell you what we would do. Since it would cost us $20,000.00-$27,000.00 annually to provide eighteen people with health insurance, we would do one or more of the following:

1) Discharge two employees.
2) Reduce all salaries.
3) Reduce working hours.
4) Replace higher salaried employees with part time minimum wage employees.
5) Dissolve the corporation.

Veterinary hospital, Vicksburg, Mississippi

We have and are continuing to experience very tough price competition from overseas. Any increase in our cost of operations will have an adverse affect on our United States operations. This is especially true in regards to employment and benefits. We already have laid off 15% of our domestic work force due to the high cost of operations.

Manufacturing firm with 1,900 employees,
Northbrook, Illinois

Many of our employees have worked for us longer than ten years, and this longevity is certainly not typical of our industry. So we must be doing something right. We currently pay in excess of 70% of our gross revenues in direct payroll, required employer match, unemployment taxes, and fringe benefits. There is NO POSSIBLE WAY that we could survive if this bill becomes law.

There are times that I become so furious as a businessman that I feel it's time to hang it all up.

Styling salon chain, Logansport, Indiana

[Congress is] teetering on the brink of one more piece of legislation which could force the final nail in the coffin of not only my business but small businesses across America.

Automotive accessories company,
St. Petersburg, Florida

I know you are aware of the struggle to survive in our economy in south Louisiana. I urge you to oppose HR-2508 because it imposes additional burdens on employers already providing health care in a time when every penny counts. Mandated health benefits legislation must be stopped.

Bank, Belle Chasse, Louisiana

The owner, management, employees, and associates of this company would appreciate your efforts to work against H.R. 2508, S. 1265, and any other bills that would require "Mandatory Health Care Coverage."

We do provide insurance coverage for our employees, but the extent of coverage proposed in H.R. 2508 would cause my small business to cease operations.

Wastewater treatment company
Burleson, Texas

As a small businessman, this bill concerns me very much.

I don't believe that at this point in our business life cycle this bill would be too devastating. Currently, we employ approximately 85 full-time employees and are offering a health care plan which compares favorably with that of the Auto Industry. However, this would not have been possible only a few short years ago!

It seems that the only thing that isn't mandatory for a small business today is getting one started. And pretty soon, this could be eliminated through mandatory programs of big government.

I consider myself fortunate because we still had the opportunity to grow and expand employee benefits as growth allowed. I hope that S. 1265 will not become a reality and prevent other businesses the opportunity we had.

Technological firm, Frankenmuth, Michigan

Although our firm has provided health care benefits for many, many years; I am opposed to this legislation.

H.R. 2508 might be socially acceptable but the mandating of benefits is encroaching on the free enterprise system. Mandating benefits piles on increased costs and decreases our ability to compete. Keeping our free enterprise system alive and healthy so that we can pay taxes is our primary responsibility.

Manufacturing firm, Beatrice, Nebraska

It is not just the small employer who may have difficulty meeting the requirements of mandated benefits. Mandated benefits will likely capture larger percentages of total dollars devoted to compensation, with the result that non-mandated benefits could be reduced. Mandated benefits will remove the competitive environment that has resulted in the growth of so many employee benefits over the years. It can also result in the loss of important benefits to employees who prefer freedom of choice in their selection of employers.

Insurance holding company with 6,000 employees,
Headquartered in Charlotte, N.C.

We dropped disability coverage for 1987 because of the added expense of the new continued coverage law. We seriously considered dropping the medical plan entirely and still may if additional mandates are made.

Printing company, Mentor, Ohio

[Our] member companies are typically small, closely held, businesses with an average of $5 to $10 million in sales, and employing an average of 80 or fewer employees.

It is ironic that at the same time Congress acknowledged the need for American enterprises to become more competitive, you are debating the merits of this proposal.

Manufacturing businesses, particularly small businesses, can endure H.R. 2508, only at the cost of reduced employee earnings, fewer additional benefits, reduced hiring and reduced investment for future gains in productivity.

Congress can take positive steps to address the problem of the uninsured worker. For example, full tax credits as an incentive for unincorporated businesses to provide health insurance might be useful.

1,000 member manufacturing trade association
Richmond Heights, Ohio

We have managed to survive prosper and grow due to a lot of hard work and sacrifice, in a time when the small business of our type is rapidly becoming a thing of the past.

The coverage that would be required would be about equivalent to the coverage we now have for all full time employees. Costs vary on our current coverage but an average for our younger employees is $162/mo. Let's say that we had 135 seasonal employees for 6 weeks. We currently get coverage for monthly periods so we would have to cover 135 employees for 2 months. 135 x $162.00=$21,870.00 x 2 mos.=$43,740.00. If you are used to dealing with figures in the millions and billions this may not sound like much but to us it is major.

Canning company, Osgood, Ohio

We simply cannot compete if we are continually mandated to add to our already over burdened mandates!!!

Warehouse company, Spartanburg, S.C.

As a small business owner, I am very concerned over Senate Bill 1265 requiring all employers to provide employees with health care insurance.

I simply cannot afford to do that with employees without having to make my prices so high that I could not be competitive. The bill would also slow expansion of my business and cause me not to give jobs to several people in an area where the economy is already depressed.

I can understand the need for people to carry health insurance, but for companies that are just struggling to stay alive in the depressed Texas economy, having to provide this insurance to employees and their families could be our death warrant.

Rental company, Blooming Grove, Texas

This letter is in regards to H.R. 925/S. 249 (Parental Leave) and H.R. 2508/S. 265 (Mandated Health Coverage).

Presently, I work at a temporary nursing service in the northend of Seattle, WA. This nursing service is a small, locally, owned and operated business that would definately be affected by these bills should they pass.

Currently, the business employs roughly 125-150 employees and surely you could see how these bills could hurt the company.

Nursing service firm, Seattle, Washington

I feel that it is important for me to offer Health Insurance to my employees and it allows me to maintain a quality work force but it should not be mandated by the government.

Solving one problem by creating another one is not a solution and will cause far greater problems in the business climate.

Wholesale distributor, Hayward, Wisconsin

Two-thirds of all Americans without health insurance are in families whose incomes are within 200 percent of the national poverty level. These are precisely the individuals who are most likely to lose their jobs or not be hired initially if employers are required to pay thousands of dollars per year for costly health coverage.

The answer to expanding employer-provided health coverage is not to mandate that every employer provide expensive coverage--this will drive-up the cost of health care. Rather, Congress should consider lowering the cost to businesses and individuals by preempting state mandated benefits, expanding multiple employer trusts and extending modest tax incentives for broader coverage among small businesses where coverage is most lacking.

Publishing firm, Rockdale, Texas

COALITION ON MANDATED BENEFITS

A & E BLIND & AWNING COMPANY (Wichita Falls, Texas)
A CHIROPRACTIC CORPORATION (Santa Clara, California)
A. J. PERRI, INC. (Red Bank, (Middletown, New Jersey)
A.B. CHANCE COMPANY (Centralia, Maryland)
A.C.A CALUMET, INC. (Indianapolis, Indiana)
A.C.C. DELIVERY SERVICE (Corpus Christi, Texas)
A.C.M.I. (Ann Arbor, Michigan)
A.P. GREEN RETRACTORIES CO. (Mexico, Missouri)
AAA SIGN SERVICE, INC. (Johnson City, Tennessee)
ABIGAIL ABBOTT PERSONNEL COMPANIES (Tustin, California)
ABILENE WEST 70 - 76 (Solomon, Kansas)
ACCURATE HYDRAULICS INC. (Hopkinton, Massachusetts)
ACE ELECTRIC, INC. (Lafayette, Louisiana)
ACKELS FARMS, INC. (Milton, Delaware)
ACME SHEET MENTAL COMPANY, INC. (Dover, New Hampshire)
ACME UNITED CORPORATION (Fairfield, Connecticut)
ACME-CLEVELAND CORPORATION (Cleveland, Ohio)
ACTION REFRIGERATION (Littleton, Massachusetts)
AD-A-DAY-COMPANY INCORPORATED (Tacunton, Massachusetts)
ADA TECHNOLOGIES, INC. (Aurora, Colorado)
ADCOCK'S IDEAL CLEANERS (Midland, Texas)
ADDISON CHAMBER OF COMMERCE (Illinois)
ADEE HONEY FARMS (Bruce, South Dakota)
ADVANCE ALUMINUM CO. (Owensboro, Kentucky)
ADVANCE INSULATION & SUPPLY, INC. (Midlothian, Virginia)
ADVANCE SOLAR GLASS TINTING, INC. (Apache Junction, Arizona)
ADVANCED CONNECTOR TELESIS (Santa Ana, California)
ADVANCED PAPER TUBE INC. (Cleveland, Ohio)
AERIAL CO. (Marinette, Wisconsin)
AERO-TECH SERVICES, INC. (Santa Fe Springs, California)
AEROSPACE TECHNIQUES, INC. (Cromwell, Connecticut)
AFFILIATED BENEFITS SERVICES, INC. (Redding, California)
AFRICAN CHAMBER OF COMMERCE (Louisiana)
AIR PARTS (Norcross, Georgia)
AIRBORNE EXPRESS (Seattle, Washington)
AIRBORNE, INC. (Fairmont, West Virginia)
ALAMO GLASS CO. (Lafayette, Louisiana)
ALBERT LEA-FREEBORN COUNTY CHAMBER OF COMMERCE (Albert Lea, Minnesota)
ALDINE METAL PRODUCTS CORP. (Brookfield, Connecticut)
ALEXANDER & ALEXANDER OF NEW YORK, INC. (New York, New York)
ALEXANDER & ALEXANDER SERVICES, INC. (Baltimore, Maryland)
ALFA CARBURETORS (Huntington Park, California)
ALL OHIO AMBULANCE SERVICE, INC. (Columbus, Ohio)
ALL-CONSOLIDATED AUTO REBUILDERS, INC. (Harvey, Illinois)
ALLCAL REMOVAL SERVICE INC. (Santa Clara, California)
ALLEN & ALLEN COMPANY (San Antonio, Texas)
ALLENS FOOD STORE INC. (Branden, Missouri)
ALLENTOWN-LEHIGH COUNTY CHAMBER OF COMMERCE (Pennsylvania)
ALLIED INDUSTRIAL TRUCK SERVICE (Memphis, Tennessee)
ALLISON AUTO SALES (Joshua, Texas)
ALLISON BROTHERS DRILLING COMPANY (Denver, Colorado)

ALLISON OIL CO. (Denver, Colorado)
ALLISON ZION SUPPLY CO. (Denver, Colorado)
ALLSTEEL, INC. (Aurora, Illinois)
ALLSUP INSULATION CO., INC. (Waco, Texas)
ALPHA-WEST CORPORATION (Vallejo, California)
ALPI INDUSTRIAL SUPPLY (La Halran, California)
ALYCE'S FLORAL DESIGN, INC. (Ft. Walton Beach, Florida)
AMANA REFRIGERATION, INCORPORATED (Amana, Iowa)
AMBUR MACHINE COMPANY, INC. (Northbridge, Massachusetts)
AMERICAN ASSOCIATION OF SCHOOL ADMINISTRATORS
AMERICAN BOILER MANUFACTURERS ASSOCIATION
AMERICAN CHAIN DIVISION OF BABCOCK INDUSTRIES, INC. (York, Pennsylvania)
AMERICAN COLD STORAGE (Lithia Springs, Georgia)
AMERICAN ELECTRONICS ASSOCIATION
AMERICAN FEDERATION OF SMALL BUSINESS
AMERICAN MEAT INSTITUTE
AMERICAN STATE BANK (Charleston, Arizona)
AMERICAN STEEL & IRONWORKS, INC. (Denver, Colorado)
AMERICAN WELDING, INC. (Buras, Louisiana)
AMERITRUST COMPANY NATIONAL ASSOCIATION (Cleveland, Ohio)
AMEV HOLDINGS, INC. (New York, New York)
AMOCO OF BURNSVILLE (Burnsville, Minnesota)
ANDERSON AREA COUNTY CHAMBER OF COMMERCE (Anderson, Indiana)
ANDERSON COUNTY CHAMBER OF COMMERCE (Tennessee)
ANDERSON SEISMOGRAPH BIT SERVICE (Casper, Wyoming)
ANDREWS RUBBISH REMOVAL (Holden, Massachusetts)
ANDY'S PEST CONTROL, INC. (Huntsville, Alabama)
ANGST-MOTOR SERVICE (Winona, Minnesota)
ANIMAL HOSPITAL OF MT. POCONO (Pocono Summit, Pennsylvania)
ANN ARBOR AREA CHAMBER OF COMMERCE (Michigan)
ANTHONY M. GUERRERA, ESQ. (Stratford, Connecticut)
ANTHONY'S AIR CONDITIONING AND HEATING CO. (Bryan, Texas)
AP & G SALES (Longview, Texas)
APEX CHAMBER OF COMMERCE (North Carolina)
APEX RACK & COATING CO., INC. (Grand Rapids, Michigan)
AQUANAUT SCUBA CENTER (Destin, Florida)
ARGAY SALES, INC. (Minneapolis, Minnesota)
ARIZONA CONTRACTORS ASSOCIATION
ARIZONA WHOLESALE SUPPLY CO. (Phoenix, Arizona)
ARKANSAS BEST CORPORATION (Fort Smith, Arkansas)
ARKLA, INC. (Shreveport, Louisiana)
ARLINGTON ENGINEERING SUPPLY, INC. (Arlington, Texas)
ARMCO, INC. (Middletown, Ohio)
ARMSTRONG COUNTY CHAMBER OF COMMERCE (Kittanning, Pennsylvania)
ARNOLD RITTER EQUIPMENT CORPORATION (Corpus Christi, Texas)
ARROW CONSTRUCTION CO., INC. (Rawlings, Wyoming)
ART CARVED CLASS RINGS (Austin, Texas)
ARTS FLOORS AND MORE (Seattle, Washington)
ASSOCIATED INDUSTRIES OF FLORIDA
ASSOCIATED INDUSTRY OF MASSACHUSETTS
ASSOCIATION OF AMERICAN PHYSICIANS & SURGEONS (Burke, Virginia)
ASSOCIATION FOR INFORMATION & IMAGE MANAGEMENT (AIIM)
ASSOCIATION OF COMMUNITY COLLEGE TRUSTEES
ATLAS FOOD & GRAIN CO. (Clintona, Michigan)
ATLAS RESERVE TEMPORARIES, INC. (St. Louis, Missouri)

ATTAS EVALUATION NETWORK, INC. (Gibsonia, Pennsylvania)
AUGUST SIEVERS SONS COMPANY (Chicago, Illinois)
AURA SYSTEMS (Santa Ana, California)
AUSTIN STEEL & ALLOY, INC. (Olmstead Falls, Ohio)
AUTO DRIVEAWAY COMPANY (Chicago, Illinois)
AUTO-TRUCK SPRING SERVICE CO., INC. (Nashville, Tennessee)
AUTOMOTIVE PARTS (Batesville, Arkansas)
AUTOMOTIVE SERVICE ASSOCIATION
A.V. DWORAK, INC. (Longmont, Colorado)
AVCO LYCOMING TEXTRON (Stratford, Connecticut)
AVONDALE MILLS (Sylacauga, Alabama)
AYCOCK MOTERS, INC. (Batesville, Arkansas)
AYRES & BAKER POLE & POST COMPANY (Mt. View, Wyoming)
B & B CONCRETE CO. (Tupelo, Mississippi)
B & B SERVICE & SALES OF FLINT, INC. (Burton, Michigan)
B & M GARAGE (Armandville, Louisiana)
B & S TRANSPORTATION SERVICES, INC. (Oxford, Alabama)
B & T WHOLESALE INC. (Roseville, Michigan)
B.G. MOVIES AND RENTAL (Blooming Grove, Texas)
B.J. MALLARDS TAVERN (Baltimore, Maryland)
B.K. FIRE & SAFETY INC. (Dickinson, North Dakota)
BAILEY TIRE & SERVICE (Chillecothe, Illinois)
BAKER SURVEYING INC. (San Antonio, Texas)
BALL CORPORATION (Muncie, Indiana)
BALLASH PRESS INC. (Mentor, Ohio)
BALWEG CHEVROLET-OLDS-PONTIAC-BUICK, INC. (Sauk City, Wisconsin)
BANK OF HAWAII (Honolulu, Hawaii)
BANK ONE-INDIANAPOLIS (Indianapolis, Indiana)
BANKS OF MID AMERICA - FIRST TULSA (Tulsa, Oklahoma)
BARDWELL SUPPLY COMPANY, INC. (Long Beach, California)
BARNES GROUP INC. (Bristol, Connecticut)
BARTOLETTES HOTEL (Tvodericktown, Pennsylvania)
BASCOM CONSTRUCTION, INC. (Claremont, New Hampshire)
BATES & CO. (Columbus, Ohio)
BATESVILLE CONCRETE PRODUCTS (Batesville, Arkansas)
BAY PLASTICS, INC. (Burleson, Texas)
BAY-CAL CONSTRUCTION, INC. (Mt. View, California)
BAYCRAFT FIBERGLASS ENGINEERING INC. (Havre de Grace, Maryland)
BAYSHORE STATIONERS, INC. (Keyport, New Jersey)
BCI, INC. (San Jose, California)
BEAL STREET, INC. DBA TIMBERS (Fort Walton Beach, Florida)
BEAM INDUSTRIES, INC. (Webster City, Iowa)
BEAVERS DRAFTING & PLANTS (Tuscaloosa, Alabama)
BELL MANUFACTURING & SERVICES, INC. (Minneapolis, Minnesota)
BELLAIRE ELECTRIC, INC. (McDonald, Pennsylvania)
BEN FRANKLIN STORE (Abinsdon, Illionis)
BENEFIT COMPENSATION INSURANCE SERVICES (San Jose, California)
BENEFITS UNLIMITED (Morton Greeva, Illinois)
BENJAMIN FRANKLIN SAVINGS & LOAN CO. (Portland, Oregon)
BENNETT EQUIPMENT COMPANY (Longview, Texas)
BENNETT PUMP COMPANY (Muskegon Heights, Michigan)
BENSON PLUMBING INC. (Laguna Hills, California)
BENTONVILLE CASTING COMPANY (Bentonville, Arkansas)

BERGMAN NURSERIES, INC. (Quincy, Illionis)
BERKSHIRE JANITORAL SUPPLY & SERVICE (Stratford, Connecticut)
BESSER COMPANY (Alpena, Michigan)
BEST PRODUCTS CO, INC. (Richmond, Virginia)
BEST WESTERN GALAXY (Rochester, Minnesota)
BEST WESTERN INTERNATIONAL (Phoenix, Arizona)
BEST WESTERN RIVER TERRACE (Cheboygan, Michigan)
BETA SHIM CO. (Norwalk, Connecticut)
BETHLEHEM STEEL CORPORATION (Bethlehem, Pennsylvania)
BEVRMANN'S (Howeli, Michigan)
BFA, INC. (Baytown, Texas)
BICKELS MEAT CENTER, INC. (Omaha, Nebraska)
BICKLER LANDSCAPE MAINTANENCE (Waukesha, Wisconsin)
BID-WELL (Canton, South Dakota)
BIG SKY CABINETS, INC. (Helene, Montana)
BILL FISH REALTY, INC. (Destin, Florida)
BILL'S SUPER VALUE (Lemmon, South Dakota)
BIRCHWOOD LABORATORES, INC. (Eden Prairie, Minnesota)
BIRDWELL CLEANING AIDS, INC. (Keene, Texas)
BLACKMON'S INC. (Winnsboro, Louisiana)
BLACKSMITH BAKERY (Hanover, New Hampshire)
BLOOMIN' THINGS (Henderson, Kentucky)
BLUE SHIELD OF CALIFORNIA (San Francisco, California)
BLYTHE CHAMBER OF COMMERCE (California)
BMY-TVO (York, Pennsylvania)
BO'S MARINE (Natchitoches, Louisiana)
BOB WOLTERSDORF AUTOMOTIVE TRANSPORTATION SERVICE (San Antonio, Texas)
BOB'S BLACKSMITH SHOP (Stockport, Iowa)
BOB'S BUDGET PHARMACY (Tucumcari, New Mexico)
BOND THE FLORIST (Pauls Valley, Oklahoma)
BONNER'S EXXON (Fairfield, Texas)
BONTRAGER INC. (Columbus, Indiana)
BOONE COUNTY NATIONAL BANK (Columbia, Missouri)
BORO BUSSES COMPANY (Red Bank, New Jersey)
BORO LAKESIDE BEVERAGE (Edinboro, Pennsylvania)
BOSTON PERCISION PARTS COMPANY (Hyde Park, Massachuetts)
BOWATER CAROLINA COMPANY (Catawba, South Carolina)
BOXBOARD PACKAGING COMPANY (Norwalk, Ohio)
BOYD'S PHARMACY (Alto, Texas)
BOYLE FOOD CENTER (Boyle, Missouri)
BOZEMAN FORD LINCOLN MERCURY (Bozeman, Montana)
BRANCH BANKING AND TRUST COMPANY (Wilson, North Carolina)
BRANCH INTERMEDIATE SCHOOL DISTRICT (Coldwater, Michigan)
BRANCH-SMITH, INC. (Fort Worth, Texas)
BRANDT TOOL & DIE (Littlestown, Pennsylvania)
BRB CONTRACTORS, INC. (Topeka, Kansas)
BRECKENRIDGE CHAMBER OF COMMERCE (Breckenridge, Texas)
BRECKENRIDGE RESORT CHAMBER OF COMMERCE (Colorado)
BREN-DAN, INC. (Stamford, Connecticut)
BRICO INDUSTRIES, INC. (Elmhurst, Illionis)
BRIGHTON CHAMBER OF COMMERCE (Colorado)
BRIO SCANDITOY (Milwaukee, Wisconsin)
BRISTOL INDUSTRIES (Brea, California)
BRITT FABRICATORS & MACHINE SHOP (Mitter, Georgia)
BROCKWAY INCORPORATED (Jacksonville, Florida)

BROOKSHIRE GROCERY COMPANY (Tyler, Texas)
BROWN & SON LUMBER COMPANY INC. (Pottersville, New York)
BROWN'S WINDSOR DOOR SALES, INC. (Longview, Texas)
BROWNELL DRUG (St. Charles, Minnesota)
BROWNLOW GULF (Little Rock, Arkansas)
BRUMLINE USA, INC. (Suphur, Louisiana)
BRUNN-ULMER CONSTRUCTION CO. (Kansas City, Kanas)
BRUNNER PRINTING COMPANY (Batesville, Arkansas)
BRUNSWICK CORPORATION (Skokie, Illinois)
BRUSH WELLMAN, INC. (Cleveland, Ohio)
BUCK KNIVES, INC. (El Cajon, California)
BUD & SHIRLEY'S RESTAURANT & MOTEL (Darby, Montana)
BUD JENNINGS & SONS CARPETS, INC. (Lawrence, Kansas)
BUDDY'S ELECTRO (Martinez, Georgia)
BUDGET LOAN CORPORATION (Navasota, Texas)
BUILDING COMPONENTS CORPORATION (Towson, Maryland)
BULTMAN, INC. (Ulysses, Kansas)
BURD & BURD (Yakima, Washington)
BURNS & SONS COLLISION (Flint, Michigan)
BURNS CLINIC MEDICAL CENTER, P.C. (Petoskey, Michigan)
BUSIEK-JONES AGENCY (Bryan, Texas)
BUSINESS COUNCIL OF GEORGIA
BUSINESS DEVELOPMENT CENTER OF BOULDER COUNTY (Boulder, Colorado)
BUSINESS SYSTEMS OF NORTHWEST FLORIDA, INC. (Destin, Florida)
BYRD-DUFFIE FORMS, INC. (Danville, Virginia)
C & C GAS CO. (Brownsboro, Texas)
C & Y TRANSPORTATION COMPANY, INC. (Casper, Wyoming)
C C & T CABINETS (Irving, Texas)
C. BREWER & CO., LTD. (Honolulu, Hawaii)
C. EARL BROWN, INC. (Chambersburg, Pennsylvania)
C.A. REED, INC. (Williamsport, Pennsylvania)
C.B. JENSEN & ASSOCIATES, INC. (Troy, Michigan)
C.B.N. BUILDING MAINTENANCE (Phoenix, Arizona)
C.F. TOMPKINS COMPANY (Salem, Massachuetts)
C.I. HAYES INCORPORATED (Cranston, Rhode Island)
CADCO (Corpus Christi, Texas)
CADY GRAIN CO., INC. (Deer Grove, Illinois)
CAL-COL INDUSTRIES, INC. (Colorado Springs, Colorado)
CALCASIEU REFINING COMPANY (Lake Charles, Louisiana)
CALDWELL BANKER TOWN & COUNTY REALTY (Kearney, Nebraska)
CALDWELL LUMBER COMPANY (Wynne, Arkansas)
CALIFORNIA BENEFITS (Poway, California)
CALIFORNIA CHAMBER OF COMMERCE
CALLAIS FOOD STORE INC. (St. Bernard, Louisiana)
CALMAT COMPANY (Los Angeles, California)
CAMDEN-CLARK MEMORIAL HOSPITAL (Parkersburg, West Virginia)
CAMERON FOOD MART, INC. (Cameron, Louisiana)
CAMERON IRON WORKS, U.S.A. INC. (Houston, Texas)
CAPROCK BUSINESS FORMS, INC. (Lubbock, Texas)
CAPT ANDERSON II (Clearwater, Florida)
CARDINAL BUILDING MATERIALS, INC. (Springfield, Illionis)
CARL SANDBERG AND ASSOCIATES (Mesa, Arizona)
CARNEY'S OFFICE EQUIPMENT, INC. (Bakersfield, California)
CAROLINA MEDICAL ELECTRONICS, INC. (King, North Carolina)
CAROLINA POWER & LIGHT CO. (Raleigh, North Carolina)

CAROLINA STEEL CORPORATION (Greensboro, North Carolina)
CARRINGTON AREA CHAMBER OF COMMERCE (Carrington, North Dakota)
CARROLL AIR SERVICE, INC. (Kingston, New York)
CARSON AUTOMOTIVE (Bryan, Texas)
CARVEL STORE (Whitestone, New York)
CATHY A. JOSEPH, D.C., W. RICHARD KIDD, D.C. -
CBS INC.(New York, New York)
CCB FINANCIAL CORPORATION (Durham, North Carolina)
CENEX/LAND O'LAKES AG SERVICES (St. Paul, Minnesota)
CENTENNIAL LEASING CO. (Denver, Colorado)
CENTRAL CATERING (Hawarden, Iowa)
CENTRAL GARAGE (St. Petersburg, Florida)
CENTRAL SOYA COMPANY, INC. (Fort Wayne, Indiana)
CENTRAL STATES WATERPROOFING OF MISSOURI, INC. (Earth City, Missouri)
CENTURION SAFE & LOCK, INC. (Baltimore, Maryland)
CENTURY ALPHA, INC. (Waco, Texas)
CHA-MAR PROPERTIES (College Station, Texas)
CHACO, INC. (Bushnell, Illinois)
CHASE & AVERY, INC. (Newport, New Hampshire)
CHERRY PATCH MINI MART (Zellahi, Washington)
CHESHIRE EMPLOYMENT SERVICE, INC. (Keene, New Hampshire)
CHILD OF MINE (Mesa, Arizona)
CHIMO DENTAL CERAMICS (Mesa, Arizona)
CHIPPEWA MARBLE COMPANY (Columbia Station, Ohio)
CHRISTENSEN FUNERAL HOME, INC. (Ida Grove, Iowa)
CIRCLE LUMBER COMPANY (Waco, Texas)
CIRCUT DRILL INC/CIRCUIT CHECK INC./CERTRONIX INC. (Minnetonra, Minnesota)
CISCO'S STEAK HOUSE (Nashville, Tennessee)
CITIZENS SAVINGS BANK (Ithaca, New York)
CITIZENS STATE BANK OF LOYAL (Loyal, Wisconsin)
CITY ELECTRIC (Corsicank, Texas)
CITY OF GREENSBORO (Greensboro, North Carolina)
CITY PUBLISHING COMPANY, INC. (Independence, Kansas)
CITY VAN & STORAGE CO. (Tuscon, Arizona)
CLARENCE KNIGHT, INC. (Layton, Montana)
CLARK SEALS LTD. (Tulsa, Oklahoma)
CLARKE'S AUTO BODY (Alexandria, Minnesota)
CLAUDE MANN & ASSOCIATES, INC. (Wichita, Kansas)
CLAYTON POINT FERTILIZER, INC. (Franklin, Illinois)
CLEARY CLEANERS (Rochester, New Hampshire)
CLIFF ZARSKY TEXAN HOMES (Corpus Christi, Texas)
CLINTONVILLE SERVICECENTER, INC. (Columbus, Ohio)
CLITHERALL LIQUORS INC. (Clitherall, Minnesota)
CLUB MANAGERS ASSOCIATION
CMI CORPORATION (Oklahoma City, Oklahoma)
CMP CORPORATION (Oklahoma City, Oklahoma)
COACH & FOUR (Ft. Walton Beach, Florida)
COACHMAN INDUSTRIES (Elkhart, Indiana)
COAST TO COAST (Plainview, Minnesota)
COASTAL HYDRAULIC CRANES, INC. (Houston, Texas)
COLLISION SAFETY ENGINEERING, INC. (Overn, Utah)
COLORADO BUSINESS COALITION FOR HEALTH
COLORADO PRECAST CONCRETE, INC. (Loveland, Colorado)
COLORAMA AD PRODUCTS, INC. (San Antonio, Texas)
COLUMBUS BUTANE COMPANY (Columbus, Texas)

COLWELL BROTHERS, INC. (Watertown, New York)
COMFORT INN (Destin, Florida)
COMMERCE AND INDUSTRY ASSOCIATION OF NEW JERSEY
COMPUTERLAND OF CENTRAL GEORGIA (Macon, Georgia)
COMPONENT MANUFACTURING COMPANY (Sioux Falls, South Dakota)
CONCHAS NORTH DOCK MARINA (Conchas Dam, New Mexico)
CONCOR TOOL & MACHINE INC. (Hayward, Wisconsin)
CONCRETE SUPPLY COMPANY (Charlotte, North Carolina)
CONKLIN CO., INC. (Shakopee, Minnesota)
CONNOR COMPANY (Peoria, Illinois)
CONRAC CORPORATION (Stamford, Connecticut)
CONSOLIDATED CARD CO., INC. (York, Pennsylvania)
CONSTRUCT PLUS, INC. (Manchester, New Hampshire)
CONTEL CORPORATION (Atlanta, Georgia)
CONTINENTAL ILLINOIS CORPORATION (Chicago, Illinois)
CONTINENTAL WESTERN INSURANCE COMPANY (Des Moines, Iowa)
COON DEVISSER CO. (Royal Oak, Michigan)
COOPER'S CHAIRS, INC. (Lynnwood, Washington)
CORBETT & COOK, INC. (Ft. Walton Beach, Florida)
CORBIN CHAMBER OF COMMERCE (Corbin, Kentucky)
CORCKETT INN, INC. (Crockett, Texas)
CORNELIUS FITZGERALD & CO., INC. (New York, New York)
CORNING GLASS WORKS (Corning, New York)
CORONADO CHAMBER OF COMMERCE (California)
CORTLAND CORSET CO. INC. (Cortland, New York)
COUNTRY GAS & SERVICE COMPANY (Hunlock Creek, Pennsylvania)
COUNTY CHAMBER OF COMMERCE, INC. (White Plains, New York)
COUNTY RESILIENT FLOOR CO. (Pleasantville, New York)
COVER TECH MARINE DESIGNS (Destin, Florida)
COVER TEMP (White Plains, New York)
COVINA CHAMBER OF COMMERCE (Covina, California)
CRANE CREEK ASPHALT, INC. (Uwatonna, Minnesota)
CRAWFORD AUSTIN MANUFACTURING CO. (Waco, Texas)
CRAWFORD FITTING COMPANY (Socon, Ohio)
CREATIVE COATINGS, INC. (Kilgore, Texas)
CREATIVE MARBLE INC. (Evans, Georgia)
CREEGEN'S (Luverne, Massachusetts)
CROSBY/HUFFMAN CHAMBER OF COMMERCE (Crosby, Texas)
CROSSVILLE RUBBER PRODUCTS (Crossville, Tennessee)
CROWN COCA-COLA BOTTLING COMPANY (Jacksonville, Texas)
CROWN JEWELRY INC. (Great Falls, Montana)
CUBIC CORPORATION (San Diego, California)
CULLIGAN WATER CONDITIONERS, INC. (Miami, Florida)
CULLMAN APOTHECARY (Cullman, Alabama)
CURREY TITLE COMPANY, INC. (Crockett, Texas)
CUSTOM PLASTERING & DESIGNS (Leicester, Massachusetts)
CUTTER AVIATION, INC. (Phoenix, Arizona)
D & D TOL COMPANY, INC. (Eatontown, New Jersey)
D & K TRUCK COMPANY (Lansing, Michigan)
D & W TROPHY HOUSE (Corpus Christi, Texas)
D J CREATIONS, INC. T/A PIP PRINTING (Holyoke, Massachusetts)
D'ELIA-EASTMAN MOTOR CAR CO., INC. (Stamford, Connecticut)
D.G. QUINTON COMPANY, INC. (Spokane, Washington)
D.I.S. (Stratford, Conneticut)
D.J. TRANSFER CO., INC. (Kansas City, Kansas)

DAHLMAN'S COUNTRY CARPET SHOPPE (Hartville, Ohio)
DAKOTA ELECTRONICS (Aberdeen, South Dakota)
DALLAS CORPORATION (Dallas, Texas)
DALLISON LUMBER INC. (Jacksonburg, West Virginia)
DAN GARDNER, M.D. (Benton, Arkansas)
DANA C. MATTHEWS, P.A. (Destin, Florida)
DANICE MANUFACTURING CO. (South Lyon, Michigan)
DANNY P. BOYLE, D.D.S. (Mesa, Arizona)
DANNY THOMAS MANAGEMENT, INC. (Little Rock, Arkansas)
DARL H. GARN, M.D. (Mesa, Arizona)
DASSEL RESTAURANT, INC. (Dassel, Minnesota)
DAVE REIFF PRINTING (Phoenix, Arizona)
DAVIE/COOPER CITY CHAMBER OF COMMERCE (Davie, Florida)
DAVIS & ASSOCIATES (Stockton, California)
DAY INSURANCE AGENCY, INC. (Washington, Pennsylvania)
DAYTON, COREY & DUBBEN, INC. (Pleasantville, New York)
DCI INC. (St. Cloud, Minnesota)
DEACONESS HOSPITAL (Evansville, Indiana)
DEAKINS METAL SPINNING, INC. (Brazil, Indiana)
DECATO BROTHERS, INC. (Lebanon, New Hampshire)
DECISION PLANNING CORPORATION (Costa Mesa, California)
DEKALB CORPORATION (DeKalb, Illinois)
DEKALB-PFIZER GENETICS (DeKalb, Illinois)
DELAGAR DIVISION BELCAM INC. (Rouses Point, New York)
DELSIGNORE BLACKTOP PAVING, INC. (Troy, New York)
DELTA ENGINEERING, INC. (St. Paul, Minnesota)
DELTA GULF CORPORATION (Shreveport, Louisiana)
DELTA INSURANCE ADMINISTRATORS, INC. (Las Vegas, Nevada)
DELTA OIL & INDUSTRIAL SALES (Longview, Texas)
DEMASSI CADILLAC COMPANY, INC. (Englewood Cliffs, New Jersey)
DEMCO, INC. (Madison, Wisconsin)
DEMYAN WELDING CO., Kimberton, Pennsylvania)
DENSON CONTRUCTION COMPANY, INC. (Tyler, Texas)
DENVER APARTMENT GUIDE, INC. (Aurora, Colorado)
DENVER REEL AND PALLET COMPANY (Denver, Colorado)
DEPAUL UNIVERSITY (Chicago, Illinois)
DEPENDABLE CLEANERS (Denver, Colorado)
DESERAMA TV SERVICE (Mesa, Arizona)
DESERT HARBOR RESTAURANT INC. (Scottsdale, Arizona)
DESMET FARM MUTUAL INSURANCE COMPANY (DeSmet, South Dakota)
DESTIN POOL SERVICES, INC. (Destin, Florida)
DETAIL PATTERN & MACHINE COMPANY (Hemlock, Michigan)
DETAILED-BUILDERS CO., INC. (Indianpolis, Indiana)
DEVER CHIROPRACTIC (Mesa, Arizona)
DIAMOND F. CORPORATION (Richfield, Wisconsin)
DIDDE GRAPHIC SYSTEMS CORPORATION (Emporia, Kansas)
DIDRIKSEN TRUCK-N-CAR WASH (Helena, Montana)
DIET CENTER OF YORK-KINSEY DIET CENTERS (York, Pennsylvania)
DILLINGER, INC. (Little Rock, Arkansas)
DIXON FABRICATION COMPANY (Groveport, Ohio)
DODGE CITY AREA CHAMBER OF COMMERCE (Kansas)
DOMEK CONSULTING SERVICES (San Francisco, California)
DONALD J. DUFF, CLCU, CHFC (Redding, California)
DONIS CORPORATION, INC. (Ralston, Nebraska)
DONLEY MEDICAL SUPPLY COMPANY (Lincoln, Nebraska)

DOOR TO HOPE (Salinas, California)
DORMAN & SONS, INC. (Lawrenceville, Georgia)
DORMEL PLANT NURSERY (Mesa, Arizona)
DORRANCE SUNOCO, INC. (Conyngham, Pennsylvania)
DOVER CORPORATION (New York, New York)
DOW CORNING CORPORATION (Midland, Michigan)
DOWN MEXICO WAY, INC. (Athens, Texas)
DOWTY RFL INDUSTRIES (Boonton, New Jersey)
DSSI COMPANY (San Jose, California)
DST CONTROLS (Benicia, California)
DUCK'S MOBIL & WRECKER SERVICE (Daingerfield, Texas)
DUGAN'S ENTERPRISES, INC. (Berkeley Springs, West Virginia)
DUMAINES' SERVICE STATION (Att. Mass, Massachusetts)
DUNN BRAKE & TIRE SERVICES (Waco, Texas)
DUNN TRANSMISSIONS, INC. (Tyler, Texas)
DURA-BILT PRODUCTS, INC. (Gillett, Pennsylvania)
DUREX PRODUCTS, INC. (Luck, Wisconsin)
DUSKE DESIGN & EQUIPMENT COMPANY (Hales Corners, Wisconsin)
DYER WOODTURNINGS, INC. (Houston, Mississippi)
DYNA-TEC INDUSTRIES (Atlanta, Georgia)
E & M SALES, INC. (Englewood, Colorado)
E.A. WRIGHT & SONS, INC. (Fuldale, Virginia)
E.B. SMITH CHEVROLET, INC. (Nashville, Tennessee)
E.C. JOHNSTON COMPANY (Longview, Texas)
E.G. GASKET SUPPLY, INC. (Muskego, Wisconsin)
E.H. BAKER, INC. (Needham, Massachusetts)
E.L. EDDY & SONS GARAGE, INC. (Ripley, New York)
E.L. REDMAN & ASSOCIATES (Phoenix, Arizona)
EAST ALABAMA PIZZA INC. (Albertville, Alabama)
EAST TEXAS CLARKLIFT, INC. (Longview, Texas)
EAST TEXAS UTILITY SERVICE, INC. (Jacksonville, Texas)
EATON CORPORATION (Sarasota, Florida)
EBEK FAMILY CENTER (Falmouth, Michigan)
ECONOMY PLATING COMPANY, INC. (Zionsville, Indiana)
ED HAUSER TRUCK SERVICE (Hesperia, California)
EDELMANN & ASSOCIATES, INC. (Minneapolis, Minnesota)
EDISON SAULT ELECTRIC COMPANY (Sault Saint Marie, Michigan)
EDWARDS & SONS, INC. (Marlin, Texas)
EL PASO ELECTRIC COMPANY (El Paso, Texas)
EL PASO NATURAL GAS COMPANY (El Paso, Texas)
EL SEGUNDO CHAMBER OF COMMERCE (El Segundo, California)
ELDER C.P.D. (Athens, Texas)
ELECTRIC POWER CONSULTING, INC. (Santa Clara, California)
ELECTRO-PLATING ENGINEERING CO., INC. (St. Paul, Minnesota)
ELK YARN MILLS, INC. (Fayetteville, Tennessee)
ELKHORN HATCHERY, INC. (Elkhorn, Mississippi)
ELM ENTERPRISES (Cheyenne, Wyoming)
EMERALD COAST DISTRIBUTORS, INC., FURNITURE DISTRIBUTORS (Ft. Walton Beach, Florida
EMERALD SERVICES INC. (Bloomination, Indiana)
EMPIRE OVERALL (Elmwood Park, New Jersey)
EMPLOYERS INSURANCE OF TEXAS (Dallas, Texas)
ENDISCO SUPPLY CO., INC. (Tulsa, Oklahoma)
ENDWELL TRAVEL, INC. (Endwell, New York)
ENERGAS COMPANY (Amariello, Texas)
ENERGY SPROUTS, INC. (San Antonio, Texas)

ENGLEWOOD RENTAL COMPANY (Englewood, Colorado)
ENNIS MOTORCYCLE SALES, INC. (Ennis, Texas)
ENNIS TRANSPORTATION COMPANY, INCORPORATED (Ennis, Texas)
ERIE BUSINESS COALITION FOR HEALTH CARE COST CONTAINMENT (Erie, Pennsylvania)
ERIK R. ELLINGSON & ASSOC., LTD. (Edina, Minnesota)
ERIN BENEFIT GROUP, LTD. (Lancaster, Pennsylvania)
ERWIN & SHAFTER, INC. (Frederick, Maryland)
ETTEL & FRANZ COMPANY (St. Paul, Minnesota)
EVANCIEW, INC. (Rome, New York)
EVANS ENGINEERING INC. (Greensboro, North Carolina)
EVANS INDUSTRIAL COMMUNICATIONS, INC. (Madison, Wisconsin)
EVANS TIRE SERVICE INC. (Marlin, Texas)
EVER-SOFT WATER CONDITIONER (Morgansville, Maryland)
EXCALIBUR PAINT & BODY (Houston, Texas)
EXCEL MACHINE PRODUCTS, INC. (Anaheim, California)
EYE, EAR, NOSE & THROAT CLINIC (Vicksburg, Mississippi)
F & T DISTRIBUTING CO., INC. (Ithaca, New York)
F.A. MCGREGOR (Denver, Colorado)
F.H. LANGSENKAMP COMPANY, INC. (Indianapolis, Indiana)
F.J. PAINE CO., INC. (Rochester, Minnesota)
F.W. HARDY CORPORATION (Pomona, California)
FABRIKO, INC. (Green Lake, Wisconsin)
FANTASTIC SAM'S (Binghamton, New York)
FARMERS FEED & SUPPLY CO. (Sequin, Texas)
FARMERS INSURANCE CO. (Mesa, Arizona)
FARMERS STATE BANK (Lester Prairie, Minnesota)
FARMERS UNION INSURANCE (Mott, North Dakota)
FERGUSON ELECTRIC & AIR CONDITION SERVICE (Ennis, Texas)
FERNALD LUMBER, INC. (Nottingham, New Hampshire)
FERNDALE PHARMACY (Ferndale, Washington)
FIBER-SEAL OF LOS ANGELES, INC. (Los Angeles, California)
FIBREX CORPORATION (Burlington, Washington)
FIELD AGENCY, INC. (Texhoma, Oklahoma)
FIGGRE INTERNATIONAL, INC. (Richmond, Virginia)
FINKE MONUMENT EQUIPMENT CO., INC. (Wentzville, Missouri)
FINLAND INN (Pennsburg, Pennsylvania)
FINLEY & COOK (Shawnee, Oklahoma)
FINNEGAN'S DOCKSIDE CAFE (Ft. Walton Beach, Florida)
FINNISH-AMERICAN REST HOME (Lakeworth, Florida)
FIRST FEDERAL SAVINGS BANK AND TRUST (Pontiac, Michigan)
FIRST NATIONAL BANK OF WARSAW (Warsaw, Indiana)
FIRST NATIONAL SUPERMARKETS, INC. (Windsor Locks, Connecticut)
FIRST STATE BANK (Castle Rock, Minnesota)
FIRST TENNESSEE NATIONAL CORPORATION (Memphis, Tennessee)
FIRST UNITED STATE CREDIT UNION (Mesa, Arizona)
FIRST VERMONT BANK & TRUST CO. (Rutland, Vermont)
FIRST WACHOVIA CORPORATION (Winston-Salem, North Carolina)
FISH & LEBEAU SIGNS (Minneaplis, Minnesota)
FITZGIBBONS ASSOCIATIONS, INC. (Syracuse, New York)
FLINCHBAUGH ENGINEERING INC. (York, Pennsylvania)
FLOOR CARE, INC. (Batesville, Arkansas)
FLOOREVEN CARPET CO. (Mesa, Arizona)
FLORIDA NATIONAL BANK
FLORIDA SOCIETY OF ASSOCIATION EXECUTIVES
FMC CORPORATION (Chicago, Illinois)

FOAMSEAL, INC. (Oxford, Michigan)
FOLEY HYDRAULICS, INC. (Wise, Virginia)
FOLLEN WOOD PRESERVING COMPANY (Jackson, Mississippi)
FOOD MARKETING INSTITUTE
FOODSERVICE & LODGING INSTITUTE
FORENSIC ENGINEERS (Salt Lake City, Utah)
FOR SALE BY OWNER REALTY (York, Pennsylvania)
FOREIGN CAR CLINIC (Melbourne, Florida)
FOSKEY TIRE COMPANY, INC. (Vidalia, Georgia)
FOUNDATION TECHNOLOGY, INC. (Seminole, Florida)
FOUR STAR SALES & ENGINEERING, INC. (St. Petersburg, Florida)
FOX CITIES AREA CHAMBER OF COMMERCE AND INDUSTRY (Wisconsin)
FOXMOOR SPECIALTY STORES (Scottsdale, Arizona)
FRANK PORTH CHEVROLET-BUICK, INC. (Columbus, Wisconsin)
FRANKFORT FOODS, INC. (Frankfort, Illinois)
FRANKLIN WEB PRINTING COMPANY (Franklin, Tennessee)
FRED G. ANDERSON, INC. (Minneapolis, Minnesota)
FRED WILLIAMS, INC. (Randolph, Massachusetts)
FREDERICK A. FARRAR, INC. (Keene, New Hampshire)
FREE STATE ADJUSTERS, INC. (Baltimore, Maryland)
FREE STATE ADJUSTERS, INC. (Owings Mills, Maryland)
FREESTONE CHIROPRICTIC (Mesa, Arizona)
FREIGHTLINER CORPORATION (Portland, Oregon)
FRIEDMAN RECYCLING CO. (Phoenix, Arizona)
FRIEND LABORATORY, INC. (Waverly, New York)
FROHLICH'S SUPER VALU (Coon Rapids, Iowa)
FRY'S GARAGE INC. (Mt. Sterling, Illionis)
FUCHS MACHINERY, INCORPORATED (Omaha, Nebraska)
FULLERTON HARDWARE INC. (Fullerton, California)
FURATELL INDUSTRIES (Cameron, Wisconsin)
FURMAN BUILDERS, INC. (Rockville, Maryland)
FUTURE HOME FURNITURE, INC. (Oil City, Pennsylvania)
FYF CORPORATION (Paramus, New Jersey)
G. CONWAY, INC. (Charlestown, Massachusetts)
G.C. MURPHY COMPANY (McKeesport, Pennsylvania)
GAINER BANK (Merrillville, Indiana)
GALAXY BRAXING CO., INC. (Santa Fe Springs, California)
GARNER DENTAL LABORATORY (Memphis, Tennessee)
GARY CONSTRUCTION (Jennings, Louisiana)
GARY JAMES MANUFACTURING (Huntington, Park)
GARY M. LOAR PLUMBING & HEATING (Cresaptown, Maryland)
GARY P. RUCHIN & ASSOCIATES (Vernon, Connecticut)
GARY'S RED OWL (Dasser, Minnesota)
GATER INDUSTRIES, INC. (Cheyenne, Wyoming)
GATEWAY BUILDING CONSTRUCTION & LUMBER CORPORATION (Wills Point, Texas)
GATX CORPORATION (Chicago, Illinois)
GENE N. COPE, A.S.A. (Lafayette, Louisiana)
GENE'S BEARINGS (Antigo, Wisconsin)
GENERAL BINDING CORPORATION (Northbrook, Illinois)
GENESCO, INC. (Nashville, Tennessee)
GENTILLY SERVICE, INC. (New Orleans, Louisiana)
GENTRY, MOSS & GOSS (Mesa, Arizona)
GEO. STEELE COMPANY, INC. (Butte, Montana)
GEORGE C. BRANDT, INC. (St. Paul, Minnesota)
GEORGE D. HANBY CO., INC. (Wilmington, Delaware)

GEORGE R. WHITE, Geologist (Lafayette, Louisiana)
GEORGE'S GALLERY (Danielson, Connecticut)
GEOSOURCE, INC. (Houston, Texas)
GIBSON PRODUCTS COMPANY OF LAUREL, INCORPORATED (Laurel, Mississippi)
GIBSON TV & SEWING CENTER (Ennis, Texas)
GLASNAPP TOOL & DIE, INC. (Fullerton, California)
GLASS FINANCIAL GROUP (Phoenix, Arizona)
GLEN FUNERAL HOME (Owensboro, Kentucky)
GLENDALE CHAMBER OF COMMERCE (California)
GLENDALE OIL SERVICE, INC. (Glendale, Rhode Island)
GLOVER'S LOCK SERVICE (Clarksville, Tennessee)
GME, INC. (Jacksonville, Texas)
GOPHER STATE EXPOSITIONS, INC. (St. Cloud, Minnesota)
GORE KEMP ENTERPRISES, INC. (Kilgore, Texas)
GORHAM/SCHAFFLER, INC. (Memphis, Tennessee)
GORST LAW OFFICES (Marshfield, Wisconsin)
GOUGH MOTOR CO. (Bryan, Texas)
GRAHAM EMBROIDERY COMPANY (Waco, Texas)
GRAHAM FINE VALUE HARDWARE (Grayville, Illinois)
GRANBY COUNTRY GRAIN, INC. (Granby, Massachusetts)
GRANT COUNTY CHAMBER OF COMMERCE (Kansas)
GRAVES CONSTRUCTION & RENTAL, INC. (Anaheim, California)
GREASE 'N GO (Mesa, Arizona)
GREAT FALLS CLINIC (Great Falls, Montana)
GREATER BLUEFIELD CHAMBER OF COMMERCE (Bluefield, West Virginia)
GREATER CHERRY HILL CHAMBER OF COMMERCE (Cherry Hill, New Jersey)
GREATER DECATUR CHAMBER OF COMMERCE (Decatur, Mississippi)
GREATER LAFAYETTE CHAMBER OF COMMERCE (Lafayette, Indiana)
GREATER PITTSBURGH CHAMBER OF COMMERCE (Pittsburgh, Pennsylvania)
GREATER PORTLAND BUSINESS GROUP ON HEALTH (Portland, Oregon)
GREATER RENTON CHAMBER OF COMMERCE (Washington)
GREATER RIVERSIDE CHAMBERS OF SOUTHERN CALIFORNIA (Riverside, California)
GREATER SPRINGFIELD CHAMBER OF COMMERCE (Springfield, Illinois)
GREATER VANCOUVER CHAMBER OF COMMERCE (Washington)
GREATER WATERBURY CHAMBER OF COMMERCE (Connecticut)
GREATER WILLIMANTIC CHAMBER OF COMMERCE (Connecticut)
GREEN BAY AREA CHAMBER OF COMMERCE (Green Bay, Wisconsin)
GREENHECK FAN CORPORATION (Schofield, Wisconsin)
GREYHOUND FOOD MANAGEMENT (Phoenix, Arizona)
GRIFFIN ENVIRONMENTAL CO., INC. (Syracuse, New York)
GRIMES HOLSTEIN FARM, INC. (Cleveland, Washington)
GROLIER, INC. (Danbury, Connecticut)
GUARDIAN RENT-A-CAR (Ft. Walton Beach, Florida)
GULF POWER COMPANY (Pensacola, Florida)
GULF STATES UTILITIES (Beaumont, Texas)
GULFSHORE PROPERTIES, INC. (Destin, Florida)
GUNTER SIGNS, INC. (Corpus Christi, Texas)
H & N FOODS (Van Buren, Arkansas)
H & P WIRELINE, INC. (Corpus Christi, Texas)
H & S FREIGHT AGENTS, INC. (Yakima, Washington)
H & S HOME CENTER (Ardmore, Oklahoma)
H.G. ROTZ ASSOCIATES, INC. (York, Pennsylvania)
H.P. CUMMINGS CONSTRUCTION COMPANY (Warg, Massachusetts)
HAIR TODAY (Ripon, Wisconsin)
HANES COMPANIES, INCORPORATED (Winston Salem, North Carolina)

HANNIBAL COURIER POST (Hannibal, Missouri)
HANOVER AREA CHAMBER OF COMMERCE (Pennsylvania)
HAROLD DURHAM, JEWELER (Athens, Texas)
HARRIS TEETER (Charlotte, Virginia)
HARTFORD INSURANCE GROUP (Hartford, Connecticut)
HARTLEY OIL COMPANY, INC. (Rovenswood, West Virginia)
HARVEY ADVERTISING CO. (Waco, Texas)
HAUPER PHARMACY INC. (Union Grove)
HAVEN HOMES HEALTH CENTER (Hastings, Minnesota)
HAVEN MIDSTATE (Fair Haven, New York)
HAYES TRAILER SALES, INC. (Longview, Texas)
HAYES-ALLISON CORPORATION (Jackson, Michigan)
HEALTH SERVICE ENTERPRISES (Mesa, Arizona)
HEART OF THE VALLEY CHAMBER OF COMMERCE, INC. (Kaukauna, Wisconsin)
HEMET CHAMBER OF COMMERCE (California)
HENRY COUNTY CHAMBER OF COMMERCE (McDonough, Georgia)
HERMANSON DENTAL LABS, INC. (St. Paul, Minnesota)
HERRIN WELDING SERVICE, INC. (Kilgore, Texas)
HERSH PACKING & RUBBER COMPANY (Canal Winchester, Ohio)
HERSHEY CHOCOLATE COMPANY (Hershey, Pennsylvania)
HI-GLOSS COATING COMPANY (Lexington, North Carolina)
HIGHLAND RENT ALL, INC. (Albee, New Mexico)
HILL PRINTING COMPANY (Huntsville, Alabama)
HILTONHEAD ISLAND CHAMBER OF COMMERCE (Hiltonhead, South Carolina)
HINDLEY MANUFACTURING COMPANY, INC. (Cumberland, Ohio)
HISHAM HITO, M.D. (Las Vegas, Nevada)
HOAGLAND'S AUTO BODY, INC. (Concord, New Hampshire)
HOELSCHER FUNERAL HOME (Rosebud, Texas)
HOFFMAN INSURANCE SERVICES, INC. (Wellesley, Massachusetts)
HOLADAY INDUSTRIES, INC. (Eden Prairie, Minnesota)
HOLY CROSS CEMETERY (San Diego, California)
HOME LIFE INSURANCE COMPANY OF TEXAS (San Augustine, Texas)
HOMES OF DISTINCTION MILLWORK & SERVICES (Collegeville, Texas)
HONDO CHAMBER OF COMMERCE (Hondo, Texas)
HOPKINSVILLE-CHRISTIAN COUNTY CHAMBER OF COMMERCE (Kentucky)
HOSPITAL AND LAUNDRY SERVICES (Billings, Montana)
HOUSE OF CARPET (Moline, Illinois)
HOUSE OF VIDEO (Clarksville, Tennessee)
HOUSTON COUNTY CHAMBER OF COMMERCE (Houston, Texas)
HUBERS BUS COMPANY (Ferndale, Glen Burnie,)
HUDSON COUNTY CHAMBER OF COMMERCE (Jersey City, New Jersey)
HUGHES FURNITURE SERVICE (Baltimore, Maryland)
HULA CONCRETE SERVICES, INC. (Lebanon, Tennessee)
HUMANA, INC. (Louisville, Kentucky)
HUMBLE AREA CHAMBER OF COMMERCE (Texas)
HUNTER & ASSOCIATES (Newport News, Virginia)
HUNTER HOME FURNITURE (Wynne, Arkansas)
HUNTINGTON HOSPITAL ASSOCIATION (Huntington, New York)
HYDROMOTION, INC. (Spring City, Pennsylvania)
HYNES INDUSTRIES INC. (Youngstown, Ohio)
HYSTER COMPANY (Portland, Oregon)
I CARE DEVELOPMENT CENTER (Washington, D.C.)
I.S.P. COATINGS CORPORATION (Romeo, Michigan)
IBERIA PRINTING (New Iberia, Louisiana)

ICE CREAM UNLIMITED CORPORATION (Hyattsville, Maryland)
IDS FINANCIAL SERVICES (San Diego, California)
ILLINOIS CHAMBER OF COMMERCE
ILLINOIS RETAIL HARDWARE ASSOCIATION (Mt. Prospect, Illinois)
IMPERIAL SUGAR COMPANY (Sugar Land, Texas)
INDEPENDENT BAKERS ASSOCIATION
INDIA JOYE RESTAURANT (Santa Cruz, California)
INDIANA CHAMBER OF COMMERCE
INDUSTRIAL COATINGS COMPANY, INC. (York, Pennsylvania)
INDUSTRIAL ENGINEERING COMPANY (Orlando, Florida)
INDUSTRIAL FABRICATING CORPORATION (East Syracuse, New York)
INDUSTRIAL POWER & SERVICE, INC. (Longview, Texas)
INNOVATIVE TECHNOLOGY, INC. (Brooksville, Florida)
INSTY-PRINTS OF MADISON, INC. (Madison, Wisconsin)
INSULATION CONTRACTORS ASSOCIATION OF AMERICA
INSURANCE CENTER ASSOCIATES, INC. (Joplin, Missouri)
INSURANCE PLANNING SERVICES (Reno, Nevada)
INTERMOUNTAIN ADMINISTRATORS, INC. (Missoula, Montana)
INTERMOUNTAIN PLASTICS (Mesa, Arizona)
INTERNATIONAL CREATIVE METAL (Woodside, New York)
INTERNATIONAL SANITARY SUPPLY ASSOCIATION (Chicago, Illinois)
INTERSTATE FRUIT & VEGETABLE CO., INC. (Donna, Texas)
IOWA ASSOCIATION OF ELECTRIC COOPERATIVES
ISLANDER MANAGEMENT SERVICES, INC. (Destin, Florida)
ISLAND VIDEO & PRODUCTION COMPANY (Ft. Walton Beach, Florida)
ISSAQUAH GALLERY (Issaquah, Washington)
J & L TRUCKING COMPANY (Ranger, Texas)
J & M AUTOS (Otisville, Michigan)
J & M BRANDING IRON (Preston, Minnesota)
J & W WALL SYSTEMS, INC. (Holyoke, Massachusetts)
J. ANTHONY PENA TAX & FINANCIAL (Fullerton, California)
J. WADE QUINN COMPANY, INC. (Jonesboro, Arkansas)
J.A.C. INVESTMENTS (Sioux Falls, South Dakota)
J.A.M. PLASTICS (Fullerton, Caifornia)
J.D. HURON & SON (Olney, Illinois)
J.E. HARRIS CO., INC. (Mobile, Alabama)
J.E. MILLER, INC. (Syracuse, New York)
J.M. GIVAN COMPANY, INC. (Roswell, Georgia)
J.P.E. CONSTRUCTION CO. (Gordon, Georgia)
JACKSON CO., INC. (Fall River, Massachusetts)
JACKSON COUNTY AREA CHAMBER OF COMMERCE (Georgia)
JAD CORPORATION OF AMERICA (College Point, New York)
JAMES A CALDER, D.D.S. (Winnemucca, Nevada)
JAMES A. MARTIN, D.O., LTD. (Mesa, Arizona)
JAMES F. KOCHHEISER FINANCIAL SERVICES (Fresno, California)
JAMES J. KELLY & SON, INC. (New Canaan, Connecticut)
JAMES R. HOLLEY & ASSOCIATES, INC. (York, Pennsylvania)
JAROD W. OGDEN CPA (Roswell, Georgia)
JAY G. ENTERPRISES (Minneapolis, Minnesota)
JBM, INC. (Kalispeu, Montana)
JEFF'S FLOOR COVERINGS, INC. (Hueytown, Alabama)
JEFFRY GILLMAN, P.A. (South Miami, Florida)
JEMO ASSOCIATES, INC. (Westerville, Ohio)
JENKINS TRANSPORT COMPANY (Portage, Wisconsin)
JENSEN'S ORNAMENTAL INC. (Napa, California)

JERRY'S DAIRY QUEEN (Waco, Texas)
JIM NAVIS AGENCY, INC. (Racine, Wisconsin)
JIMMY'S HEATING & COOLING (Dothan, Alabama)
JOEL H. GOESCH (Yakima, Washington)
JOHN BUNNING TRANSFER COMPANY, INC. (Rock Springs, Wyoming)
JOHN COWAN & ASSOCIATES, INC. (Tyler, Texas)
JOHN D. HURN & SON (Olney, Illinois)
JOHN DAY COMPANY (Omaha, Nebraska)
JOHN E. GREEN CO. (Highland Park, Michigan)
JOHN ERICKSON CHEVROLET, INC. (Verona, Wisconsin)
JOHN G. PROCTOR GENERAL MASONRY (Lunenburg, Massachusetts)
JOHNNY CACE'S SEAFOOD & STEAK HOUSE (Longview, Texas)
JOHNNY'S MARKET CAFE (Little Rock, Arkansas)
JOHNNY'S SMOKE STAK, INC. (Rolla, Montana)
JOHNSON & THOMAS, CPA'S (Natchitoches, Louisiana)
JOHNSTON AGENCY, INC. (Henderson, Kentucky)
JON'S IGA FOOD LINER (Worland, Wyoming)
JORDAN MILLWORK CO. (Sioux Falls Co., South Dakota)
JSE MACHINERY SALES, INC. (Anaheim, Califoria)
JUMP'S RECYCLED AUTO PARTS (Ridgeley, West Virginia)
JUST DESSERTS (San Francisco, California)
K & N ELECTRIC MOTORS, INC. (Spokane, Washington)
KAAZ HOLDING COMPANY, INC. (Leavenworth, Kansas)
KAC-KA-PON RESTAURANT (Wadensville, West Virginia)
KAHRE BROS., INC. (Evansville, Indiana)
KAMINISKI LUMBER COMPANY, INC. (Blossburg, Pennsylvania)
KASAN CORPORATION (McAllen, Texas)
KASCO, INC. (Temple Hills, Maryland)
KAYSER-ROTH HOSIERY CO. (Greensboro, North Carolina)
KDRO RADIO (Sedalia, Missouri)
KEACH & GROVE AGENCY, INC. (Bedford, Indiana)
KEARNS MACHINERY COMPANY (Sioux Falls, South Dakota)
KEEN WELDING SUPPLIES INC. (Salisbury, Maryland)
KELLERMAN & ASSOCIATES (San Francisco, California)
KELLY LOGGING, INC. (Missoula, Montana)
KEN'S LAMP & SHADE SHOP (Broadway, North Carolina)
KEN'S SUPERMARKET, INC. (Aberdeen, South Dakota)
KENNEDY FINANCIAL SERVICES (San Francisco, California)
KENOSHA AREA CHAMBER OF COMMERCE (Wisconsin)
KENT'S FIRESTONE (Batesville, Arkansas)
KERMIT WELDING AND FABRICATING INC. (Kermit, Texas)
KEY HOMES (Athens, Texas)
KFIN SUPER COUNTRY 108 (Jonesboro, Arkansas)
KGC INC. (Mineapolis, Minnesota)
KINDER HAUS, INC. (Metarie, Louisiana)
KING FREDERIK MOTEL (Solvang, California)
KINGSLEY MANUFACTURING COMPANY (Costa Mesa, California)
KIRBY VACUUM CLEANERS OF SOUTHERN NEW HAMPSHIRE (Hooksett, New Hampshire)
KIRKHILL RUBBER COMPANY (Brea, California)
KITCHENS BY BENSON (Wilton, Connecticut)
KLENKE BUS SERVICE (Racine, Minnesota)
KONES KORNER (Castlewood, South Dakota)
KOTTKE TRUCKING, INC. (Buffalo Lake, Minnesota)
KRAUSS CHIROPRACTIC CENTER (Middletown, New Jersey)
KRB/KLEARKAST (York, Pennsylvaia)

L & R FORD, INC. (Lake Providence, Louisiana)
L & W, INC. (Pleasant Plains, Arkansas)
L.B. FOSTER COMPANY (Pittsburgh, Pennsylvania)
L.C.O.A. LAMINATING COMPANY OF AMERICA (Garden Grove, California)
L.T. WOOD PRODUCTS, INC. (Hazelton, West Virginia)
L.W. HODSON MACHINERY CO. (Cleveland, Ohio)
LAFE NICHOLS, D.V.M. (Henderson, Kentucky)
LAKE CITY PRINTING COMPANY (Lake City, Minnesota)
LAKE WHITNEY ENTERPRISES, INC. (Whitney, Texas)
LAKELAND GARAGE (Syracuse, New York)
LAKEWOOD FOREST PRODUCTS (Cerritos, California)
LAM-N-ART (Tuckahoe, New York)
LAMAR LIFE INSURANCE COMPANY (Jackson, Mississippi)
LANAHAN & ASSOCIATES, INC. (Martinez, Georgia)
LANCOR LIMITED (Mesa, Arizona)
LANE TRUCKING & LOGGING CO. (Chester, New Hampshire)
LANG MONUMENT CO., INC. (Morgantown, West Virginia)
LARAMIE INVESTMENT COMPANY INC. (Laramie, Wyoming)
LARGER, INC. (T/A Staley Supply) (Delmar, Maryland)
LASSALLE OIL & GAS CO. INC. (New Iberia, Louisiana)
LAURENCE F. HICKEY PLUMBING & HEATING, INC. (Waterford, Connecticut)
LAWLER'S LIQUOR STORE (Owego, New York)
LAWRENCE & NESTER DISTRIBUTING COMPANY (Danville, Virginia)
LAWSONS MANUFACUTRING CO., INC. (Morristown, Tennessee)
LAZY SUSAN (San Francisco, California)
LEE OPTICS INC. (Costa Mesa, California)
LEHIGH VALLEY HOSPITAL CENTER (Allentown, Pennsylvania)
LEOMBRUNO & ASSOCIATES (Scottsdale, Arizona)
LEON E. DARGRI, JR. (Alexandria, Louisiana)
LEOPARD MOTOR COMPANY (Corpus Christi, Texas)
LESTER ELECTRICAL OF NEBRASKA, INC. (Lincoln, Nebraska)
LETNES BROS. FRANCHISING, INC. (St. Cloud, Minnesota)
LEUPOLD & STEVENS, INC. (Beaverton, Oregon)
LIBERTY CITY STATE BANK (Kilgore, Texas)
LIBERTY DIVERSIFIED INDUSTRIES, INC. (Minneapolis, Minnesota)
LIBERTY OLDS CADILLAC (Jacksonville, Illinois)
LIDGERWOOD DRUG INC. (Lidgerwood, North Dakota)
LIFE MANUFACTURING COMPANY, INC. (East Boston, Massachusetts)
LIN-MAR DEVELOPMENT (Fallston, Maryland)
LINTON SUPPLY COMPANY (Powell, Wyoming)
LITE MAINTENANCE SYSTEMS, INC. (Edina, Minnesota)
LITTLE HANNA SANITATION, INC. (Tyler, Texas)
LITTLE RIVER VILLAGE CAMPGROUND (Townsend, Tennessee)
LITTON SYSTEMS, INC. (Woodland Hills, California)
LMS "33" CORPORATION (Phoenix, Arizona)
LOCKE MANUFACTURING, INC. (Bridgeport, Connecticut)
LOCKHEED CORPORATION (Calabasas, California)
LONG ISLAND ASSOCIATION (Commack, New York)
LONG JOHN SILVER'S (Mesa, Arizona)
LORD CORPORATION (Erie, Pennsylvania)
LOUISIANA ASSOCIATION OF BUSINESS AND INDUSTRY (L.A.B.I.)
LOUISIANE MOTEL (Natchetoches, Louisiana)
LOW STONLY HILL WOOD WORKS (Bulverde, Texas)
LUMBERMEN'S ASSOCIATION OF TEXAS
LYMAN INSURANCE AGENCY, INC. (Woburn, Massachusetts)

LYNN GRAPHICS (Stamford, Connecticut)
M & M COACH SPECIALIST (Fullerton, California)
M. GROSSMAN & SON, INC. (Passaic, New Jersey)
M. THOMAS BEETS, M.D. P.A. (Kilgore, Texas)
M.B. BELL, JR. GRAIN & GERT., INC. (Sylvania, Alabama)
M.J. VALLADARES CONSTRUCTION (East Conway, New Hampshire)
M.P. IDING COMPANY, INC. (Milwaukee, Wisconsin)
M.S. RAU, INC. ANTIQUES (New Orleans, Louisiana)
M.V. DOWNS & SONS VERSATILE CONTRACTORS (Upper Marlboro, Maryland)
MAC MURRAY PACIFIC (San Francisco, California)
MACINA, BOSE, COPELAND & ASSOCIATES, INC. (San Antonio, Texas)
MAGIC TOUGH CLEANERS (Scottsdale, Arizona)
MAGNA STEEL SALES (Bridgeport, Connecticut)
MAGNUM WIRELINE SERVICES, INC. (Giddings, Texas)
MAHONEY'S AMBULANCE SERVICE (St. Joseph, Louisiana)
MAHSHIGIAN & ASSOCIATES (Portland, Oregon)
MALLINCKRODT, INC. (St. Louis, Missouri)
MALTESE POL SERVICE, INC. (Hasbrouck Heights, New Jersey)
MALVERN CHAMBER OF COMMERCE (Arkansas)
MANISTEE COUNTY CHAMBER OF COMMERCE (Michigan)
MAPLELAND FARMS (Salem, New York)
MAPLEWOOD NURSING HOME (Webster, New York)
MARIO'S PIZZA (Owego, New York)
MARK DIEROLF (Salinas, California)
MARK FLOYD REYNOLDS, II, Attorney-at-Law (High Point, North Carolina)
MARRIOTT CORPORATION (Washington, D.C.)
MARSCHALL LINE INC. (Farmington, Minnesota)
MARSHA'S KUNTRY KITCHEN (Riesel, Texas)
MARTIN AUCTION CO., INC. (Martin, South Dakota)
MARTIN SAUML PLUMBING CO., INC. (San Antonio, Texas)
MARTIN'S WELDING (Vacaville, California)
MARVIN COX AGENCY (Kingman, Kansas)
MARYLAND ASSEMBLIES, INC. (Perry, Florida)
MARYLAND CHAMBER OF COMMERCE
MASCO CORPORATION (Taylor, Michigan)
MASON CHAMBER OF COMMERCE (Mason, Ohio)
MASSACHUSETTS ELECTRIC CONSTRUCTION CO. (Boston Mass, Massachusetts)
MASSILLON AREA CHAMBER OF COMMERCE (Massillon, Ohio)
MASTERS, INC. (Gaithersburg, Maryland)
MASTERSON'S NURSERY (Lamar, Indiana)
MAXI-MISER INC. (Ft. Walton Rock, Florida)
MAXON CORPORATION (Muncie, Indiana)
MAY FARM (King Ferry, New York)
MAYTAG COMPANY (Newton, Iowa)
MAZOMANIE-BLUE MOUNDS (Black Earth, Wisconsin)
MCANALLY ENTERPRISES, INC. (Yucaipa, California)
MCCARTY WHOLESALE LUMBER CO., INC. (Muncie, Indiana)
MCCLEARY FEED DEPOT (Mendon, Illionis)
MCCLELLAND ELECTRIC COMPANY (Edinburg, Texas)
MCELROY'S HARBOR HOUSE RESTAURANT (Biloxi, Mississippi)
MCKELLIPS FAMILY MEDICAL CLINIC (Mesa, Arizona)
MCKINNEY BODY REPAIR COMPANY (Cameron, Texas)
MCKINNEY CHAMBER OF COMMERCE (McKinney, Texas)
MCPHAIL'S PHARMACY, INC. (Oneonta, New York)
MEEKLENBORG TRACTOR & EQUIPMENT CO., INC. (Chase City, Virginia)

MEL CARLSON CHEVROLET, INC. (Truman, Minnesota)
MELEX USA, INC. (Raleigh, North Carolina)
MELLON BANK EAST (Philadelphia, Pennsylvania)
MELROSE ENTERPRISES, LTD. (Princeton, Virginia)
MELVIN BINGHAM CONTRACTOR (Bryan, Texas)
MEMORIAL FUNERAL HOME (Vidor, Texas)
MEMPHIS AREA CHAMBER OF COMMERCE (Tennessee)
MENOMONEE FALLS AREA CHAMBER OF COMMERCE (Wisconsin)
METEL TECH (Silver City, New Mexico)
METRO MECHANICS (Brooklyn Park, Minnesota)
METRO SOUTH CHAMBER OF COMMERCE (Brockton, Massachusetts)
METROPLEX ASSEMBLY SERVICES, INC. (Lewisville, Texas)
MEXIA INDUSTRIAL PRODUCTS (Mexia, Texas)
MICHAEL CLAY CONSTRUCTORS (Winnemucca, New York)
MICHAEL'S INSURANCE SERVICES (San Jose, California)
MICHIGAN STATE CHAMBER OF COMMERCE (Lansing, Michigan)
MID-AMERICA DAIRYMEN, INC. (Springfield, Missouri)
MID-LANDS CHEMICAL COMPANY (Omaha, Nebraska)
MIDWAY OFFICE & ART SUPPLY (Lewes, Delaware)
MIDWEST ENTERPRISES, INC. (Cody, Wyoming)
MILE HI MOTEL (Butte, Montana)
MILFORD AREA CHAMBER OF COMMERCE (Milford, Ohio)
MILLS FLORIST (Sturgis, Kentucky)
MILLS UNIFORM & LINEN SERVICE (Cookeville, Tennessee)
MILPITAS CHAMBER OF COMMERCE (Milpitas, California)
MINNEAPOLIS TOOL & DIE INC. (Minneapolis, Minnesota)
MINNEOPA GOLF CLUB (Mankato, Minnesota)
MINNESOTA C.A.T.V. D.B.A. CABLEVISION (Mankato, Minnesota)
MINNESOTA MUTUAL LIFE (St. Paul, Minnesota)
MINNESOTA SPECIALTY CO., INC. (Minneapolis, Minnesota)
MINUTEMAN PRESS (New Bedford, Massachusetts)
MISSISSIPPI DISCOUNT DRUGS (Canton, Mississippi)
MISSISSIPPI MANUFACTURERS ASSOCIATION
MISSOURI VALLEY FARM EQUIPMENT, INC. (Missouri Valley, Iowa)
MK BUSINESS MACHINES, INC. (Hartford, Connecticut)
MOBILE FLEET SERVICE (Yakima, Washington)
MODESTO CHAMBER OF COMMERCE (Modesto, California)
MOM'S CINNAMON ROLLS (Little Rock, Arkansas)
MONARCH BUILDING SERVICES (El Paso, Texas)
MONDEKNITTING MILLS, INC. (Middle Village, New York)
MONROE TRUCK EQUIPMENT, INC. at the following 5 locations:
Marshfield, Wisconsin
Milwaukee, Wisconsin
Monroe, Wisconsin
Joliet, Illinois
Green Bay, Wisconsin

MOORE'S MOBIL STATION & GARAGE (Coscicana, Texas)
MOOREHEAD BROTHERS, INC. (East Greenwich, Rhode Island)
MORGAN STANLEY (New York, New York)
MORTON'S INC. (Corsicana, Texas)
MOTORCYCLE EQUIPMENT, GEORGIA, INC. (Tucker, Georgia)
MOUNT SINAI HOSPITAL (Hartford, Connecticut)
MOVIE-GO-ROUND (Greenville, Mississippi)

MOVIE-GO-ROUND (Little Rock, Arkansas)
MSL FINANCIAL, INC. (Minneapolis, Minnesota)
MULTI-CARE HEALTH SERVICES CORPORATION (Fullerton, California)
MY POODLE PARLOR (Mesa, Arizona)
N & D MOTORS (Rochester, New York)
NARRAGANSETT IMPROVEMENT COMPANY (Providence, Rhode Island)
NASH FINCH COMPANY (Minneapolis, Minnesota)
NATIONAL AMERICAN WHOLESALE GROCERS' ASSOCIATION
NATIONAL APARTMENT ASSOCIATION
NATIONAL ASSOCIATION OF CONVENIENCE STORES (NACS)
NATIONAL COUNCIL FOR LABOR REFORM
NATIONAL FUEL GAS (Buffalo, New York)
NATIONAL DRYWALL, INC. (Fontana, California)
NATIONAL INDEPENDENT DAIRY-FOODS ASSOCIATION
NATIONAL MILITARY SALES, INC. (Birmingham, Alabama)
NATIONAL RESTAURANT ASSOCIATION
NATIONAL STEEL ERECTORS CORPORATION (Muskogee, Oklahoma)
NATIONAL STONE ASSOCIATION
NATIONAL TIRE DEALERS & RETREADERS ASSOCIATION
NATIONAL VIDEO (Castle Rock, Colorado)
NATIONWIDE INSURANCE COMPANY (Columbus, Ohio)
NED ADMINISTRATORS & CONSULTANTS (Sybertsville, Pennsylvania)
NEIDEN IRON & METAL CO. (Lincoln, Nebraska)
NEILL & ASSOCIATES, INC. (Mesa, Arizona)
NEODESHA CHAMBER OF COMMERCE (Neodesha, Kansas)
NESTLE' ENTERPRISES, INC. (Solon, Ohio)
NEW ENGLAND AIR SYSTEMS INC. (Essex Junction, Vermont)
NEW HORIZONS LEARNING CENTER (Waco, Texas)
NEW JERSEY BUSINESS & INDUSTRY ASSOCIATION
NEW JERSEY DIAMOND PRODUCTS (Patterson, New Jersey)
NEW JERSEY JEWELERS ASSOCIATION, INC.
NEW JERSEY STATE CHAMBER OF COMMERCE
NEWELL COMPANY (Freeport, Illinois)
NEW PARROT RESTAURANT (Watertown, New York)
NEW YORK HARWARE & FURN. CO., INC. (Monroe, Louisiana)
NEW YORK STATE ADVISORY COUNCIL ON EMPLOYMENT LAW, INC. (New York, New York)
NEWPORT PLASTICS (Newport, Vermont)
NEWTON AREA CHAMBER OF COMMERCE (Kansas)
NIBCO INCORPORATED (Elkhart, Indiana)
NICHOLS FLORIST (Revere, Massachusetts)
NICHOLS STREET AUTO SALVAGE (Springfield, Missouri)
NITC (Minneapolis, Minnesota)
NODAWAY VALLEY COMPANY (Clarinda, Iowa)
NORPIN MANUFACTURING COMPANY, INC. (Ludlow, Massachusetts)
NORTH COLORADO MEDICAL CENTER (Greeley, Colorado)
NORTH SHORE SHELL, INC. (Highland Park, Illinois)
NORTH SHREVE WELDING AND CONSTRUCTION (Shreveport, Louisiana)
NORTH STAR TOOLS, INC. (St. Charles, Minnesota)
NO2TH SUBURBAN CHAMBER OF COMMERCE (Woburn, Massachusetts)
NORTHEAST HOUSTON CHAMBER OF COMMERCE (Texas)
NORTHEAST UTILITIES SERVICE CO. (Hartford, Connecticut)

NORTHRIDGE CHAMBER OF COMMERCE (California)
NORTHSIDE ENGINE, INC. (Lafayette, Louisiana)
NORTHWAY PRODUCTS, INC. (Seattle, Washington)
NORTHWEST OUTLET, INC. (Superior, Wisconsin)
NORTHWESTERN FRUIT COMPANY (St. Paul, Minnesota)
NORTHWESTERN PUBLIC SERVICE COMPANY (Huron, South Dakota)
NORWICH MOTOR LODGE (Norwich, New York)
NTN-BOWER (Franklin, Michigan)
OAK PARK DRIVE-IN (Marengo, Iowa)
OASIS SPRINKLER SYSTEMS (Billings, Montana)
OFFICE CHAIR MAINTENANCE COMPANY (Fitchburg, Massachusetts)
OHIO SMALL BUSINESS COUNCIL OF THE OHIO CHAMBER OF COMMERCE (Columbus, Ohio)
OLD DOMINION DAY SCHOOL, INC. (Charlottesville, Virginia)
OLDE COLONIAL WOODCRAFT (W. Babylon, New York
OMANN BROTHERS, INC. (Hanover, Minnesota)
OPTIMA, INC. (Stratford, Connecticut)
ORCHIDS BY HAUSERMANN, INC. (Villa Park, Illinois)
ORLEANS & NORTHERN ESSEX HOME HEALTH AGENCY, INC. (Newport, Vermont)
ORMET CORPORATION (Hannibal, Ohio)
ORRINO ASSOCIATES, INC. (W. Babylon, New York)
OSBORNE ELECTRIC, INC. (Johnson City, Tennessee)
OSWALD MOTOR COMPANY (Cloquet, Minnesota)
OT"T" TRANSPORTATION INC. (South Boston, Massachusetts)
OTTER TAIL POWER COMPANY (Fergus Falls, Minnesota)
OTTO SAMS CORNER LOT (Middlesboro, Kentucky)
OUT TO LUNCH INC. (Little Rock, Arkansas)
OUTAGAMIE PRODUCERS COOPERATIVE (Black Creek, Wisconsin)
OUTBOARD MARINE CORPORATION (Waukegan, Illinois)
OUTLAW INN (Kalispell, Montana)
OVERHEAD DOORS & MORE, INC. (North Liberty, Iowa)
OWEGO CONTRACTING CO., INC. (Candor, New York)
OWEN'S FARM SHOP (Villard, Minnesota)
P.F.T. COMPANY (Farmer City, Illinois)
PACIFIC ADMINISTRATORS, INC. (Portland, Oregon)
PACIFIC MUTUAL (Newport Beach, California)
PALESTINE EQUIPMENT, INC. (Frankston, Texas)
PALMER'S SUPER MARKETS (Darien, Connecticut)
PANCAKE COTTAGE FAMILY RESTAURANT (Bay Shore, North Dakota)
PARAGON PRINTING COMPANY (Little Rock, Arkansas)
PARIS CUSTOM TRAILERS (Paris, Texas)
PARK CONSTRUCTION CORPORATION (Fitzwilliam, New Hampshire)
PARK RIDGE AUTO BODY (Park Ridge, Illinois)
PARKER TRANSFER AND STORAGE, INC. (Sioux Falls, South Dakota)
PARKER/HELMS SUPPLY CO., INC. (Brunswick, Georgia)
PARKVIEW CLEANERS (Watertown, New York)
PARKWAY PLASTICS INC. (West Branch, Michigan)
PARRISH CABINET COMPANY, INC. (Temple, Georgia)
PAT'S TITLE & TAG SERVICE (Hagerstown, Maryland)
PATTERSON GAS & OIL CO. (Denver, Colorado)
PATTERSON TRADING COMPANY (Tyler, Texas)
PAVILION DRAINAGE SUPPLY CO., INC. (Pavilion, New York)
PDQ PRINT & COPY SERVICE, INC. (Ft. Walton Beach, Florida)
PEARMAN OIL AND LP GAS INCORPORATED (Waxahachie, Texas)

PEASE INDUSTRIES, INC. (Fairfield, Ohio)
PEL INDUSTRIES, INC. (Rogers, Arizona)
PENINSULA SECURITY (Pt. Angeles, Washington)
PENNSYLVANIA BLUE SHIELD (Camp Hill, Pennsylvania)
PENNSYLVANIA CHAMBER OF COMMERCE
PENTAX CORPORATION (Englewood, Colorado)
PEOPLES STATE BANK OF COMFREY (Comfrey, Minnesota)
PEORIA AREA CHAMBER OF COMMERCE (Illinois)
PEREZ PRODUCTS (Bronx, New York)
PERRY AGENCY (Waterford, Connecticut)
PERSONNEL POOL OF AMERICA (Ft. Lauderdale, Florida)
PETE'S APPLIANCE (Bryan, Texas)
PETERSON CONSTRUCTION, INC. (McAllen, Texas)
PETERSON GLASS COMPANY (Chicago, Illinois)
PETRI MACHINE SHOP & SUPPLY CORPORATION (Jacksonville, Texas)
PEYTON'S RED & WHITE (Mart, Texas)
PHARMACEUTICAL MANUFACTURERS ASSOCIATION
PHILLIPS EQUIPMENT COMPANY (Tyler, Texas)
PHIL PARKS CONTRACTING, INC. (Frankston, Texas)
PHOENIX ROFFING, INC. (Dallas, Texas)
PHOENIX TRANSIT SYSTEM (Phoenix, Arizona)
PICO RIVERA CHAMBER OF COMMERCE (Pico Rivera, California)
PIEDMONT AVIATION, INC. (Winston-Salem, North Carolina)
PINSON MINING COMPANY (Winnemucca, Nevada)
PIONEER BANK OF EVANSTON (Evanston, Wyoming)
PIONEER CONCRETE & FUEL, INC. (Butte, Montana)
PIONEER ROOFING COMPANY (Phoenix, Arizona)
PIP PRINTING (Erie, Pennsylvania)
PIQUA AREA CHAMBER OF COMMERCE (Ohio)
PISTON RING SERVICE, INC. (Birmingham, Alabama)
PITMAN'S METAL WORKS (Minden, Louisiana)
PIXLEY CERIC, INC. (Englewood, Colorado)
PIZZA PIT, LTD. (Madison, Wisconsin)
PLEASANT TRAVEL LTD. (Thornwood, New York)
PLYMOUTH FIVE CENTS SAVINGS BANK (Plymouth, Massachusetts)
PLYMOUTH TUBE COMPANY (Salisbury, Maryland)
PODESTA NURSERY INC. (E. Palo Alto, California)
POLYSTONE CULTURED MARBLE, INC. (Attalla, Alabama)
PONCHA TRUCK STOP (Poncha Springs, Colorado)
PORTER & HOLMES FUNDERAL CHAPELS (Mexia, Texas)
POTTS & LEVERING, P.C. (Aurora, Nebraska)
POWELL & SATTERFIELD, INC. (Little Rock, Arkansas)
PRAIRIE VIEW REST HOME (Lewistown, Missouri)
PRATT PLUMBING & HEATING INC. (Rensselaer, New York)
PRECISION PLASTICS (Dallas, Georgia)
PRESS PROMOTIONS, INC. (Little Rock, Arkansas)
PRINCE GEORGES CHAMBER OF COMMERCE (Largo, Maryland)
PRINTWORK INC. (Greendale, Wisconsin)
PROFESSIONAL DENTAL TECHNOLOGIES (Batesville, Arkansas)
PROFESSIONAL IMAGE (Mesa, Arizona)
PRUITT RADIATOR & BATTERY SERVICE (Huntsville, Alabama)
PUBLIC SERVICE INDIANA (Plainfield, Indiana)
PURVIS BEARING SERVICE, INC. (Waco, Texas)
QUAKERTOWN FOOT CARE CENTER, INC. (Quakertown, Pennsylvania)
QUALITEK (Minneapolis, Minnesota)

QUALITY FURNITURE & APPLIANCE (Mesquite, Texas)
QUALITY MARINE, INC. (McHenry, Maryland)
QUEEN CITY INDUSTRIES (Piqua, Ohio)
QUEMAHONING COLLIERIES (Hooversville, Pennsylvania)
QUEST RESEARCH, INC. (Little Rock, Arkansas)
QUICK WEIGHT LOSS CLINIC (Mesa, Arizona)
QUINN, RACUSIN, JENKINS & RUTTENBERG CHARTERED (Washington, D.C.)
R & S CONTRACTORS, INC. (Waldorf, Maryland)
R & S ELECTRIC SUPPLY CO. (Stratford, Connecticut)
R.A. HARPER PLUMBING & HEATING, INC. (Myrtle Beach, South Carolina)
R.A. REINBOLD INSURANCE AGENCY, INC. (No. Attleboro, Massachusetts)
R.J. KOON, INC. (El Paso, Texas)
RACINEAREA MANUFACTURERS & COMMERCE (Racine, Wisconsin)
RAILROAD SALVAGE OF UNION COUNTY, INC. (El Dorado, Arkansas)
RAINBOW INTERNATIONAL (Waco, Texas)
RAINBOW INTERNATIONAL CARPET DYEING & CLEANING CO.
at the following 25 locations:
(Bloomington, Indiana)
(Fairfield, California)
(Huntsville, Alabama)
(Lynchburg, Virginia)
(Newark, Ohio)
(Pinelles Park, Florida)
(Jamestown, New York)
(Statesville, North Carolina)
(Texas City, Texas)
(Somerset Massachusetts)
(Arnold, Missouri)
(Salt Lake City, Utah)
(Tuscaloosa, Alabama)
(Phoenix, Arizona)
(Tallahassee, Florida)
(Stratham, New Hampshire)
(New Orleans, Louisiana)
(Durham, North Carolina)
(Tucson, Arizona)
(Yubo City, California)
(So. Amherst, Ohio)
(Bloomington, Indiana)
(Houston, Texas)
(Toole, Utah)
(Waco, Texas)

RAINBOW NORTH MARKET & DELICATESSEN, INC. (New Bedord, Massachusetts)
RAINIER NATIONAL BANK (Seattle, Washington)
RAM AIRCRAFT CORPORATION (Waco, Texas)
RAMSEY BROTHERS (Durham, North Carolina)
RANDY'S MOBIL (Corsicana, Texas)
RATLIFF READY MIX (Whitney, Texas)
RAY CRISWELL DISTRIBUTING COMPANY (Bryan, Texas)
RAY'S HEAT, AIR & ELECTRIC (Corpus Christi, Texas)
RAYMOND BROTHERS STEEL ERECTORS CORPORATION (Epsom, New Hampshire)

RD SEAMANS, INC. (T/A EASEWAY CONVENIENCE) (Aurburn, New York)
REALIST INC. (Menomonee Falls, Wisconsin)
REBER'S FLORIST INC. (Mount Kisco, New York)
RECORDS CONVERSION OF HOUSTON (Houston, Texas)
RED SPOT PAINT & VARNISH COMPANY, INC. (Evansville, Indiana)
REE, INC. (Beaumont, Texas)
REED HEATING & AIR CONDITIONING (Colombia, Missouri)
REELS ON WHEELS (Little Rock, Arkansas)
REFLEK CORPORATION (Fall River, Massachusetts)
REGAL WARE, INC. (Kewaskum, Wisconsin)
REIGEL ELECTRIC CORPORATION (Appleton, Wisconsin)
RELIABLE PLATING & POLISHING COMPANY, INC. (Bridgeport, Connecticut)
RENA VAKAY (Alexandria, Virginia)
RENOVATION CONCEPTS (Minneapolis, Minnesota)
RESIMAR CORPORATION (College Station, Texas)
RESLEY TIRE CO. INC. (Hagerstown, Maryland)
REX ENVIRONMENTAL, INC. (Plymouth, Mississippi)
RICHARDSON & ASSOCIATES, INC. (Washington, North Carolina)
RICHARDSON BROS WOOD PRESERVERS (Northport, Alabama)
RICHARDSON CHAMBER OF COMMERCE (Richardson, Texas)
RICHFIELD BANK & TRUST COMPANY (Richfield, Minnesota)
RINGWALD CONSTRUCTION COMPANY (Scottsdale, Arizona)
RIVARD REALITY, INC. (Ft. Walton Beach, Florida)
RIVER RIDGE REHABILITATION (Stillwater, Minnesota)
RIVERMOOR COUNTRY CLUB, INC. (Waterford, Wisconsin)
RJK ENTERPRISES, INC. (Medfield, Massachusetts)
RMC AUTOMOTIVE (Springfield, Illionis)
ROAN AIR CONDITIONING & HEATING SERVICE (West Monroe, Louisiana)
ROANE COUNTY CHAMBER OF COMMERCE (Roane, Tennessee)
ROANOKE VALLEY CHAMBER OF COMMERCE (Roanoke Rapids, North Carolina)
ROBBIE PAYNE AUTO SALES, INC. (Owensboro, Kentucky)
ROBERT A. LANG, D.D.S. INC. (Corsicana, Texas)
ROBERT A. WILBURN, INC. (De Ridder, Louisiana)
ROBERT GOFF & ASSOCIATES (Little Rock, Arkansas)
ROBERT L. HARDING, INC. (Camp Hill, Pennsylvania)
ROBIN AIDS PROSTHETICS (Vallejo, California)
ROBINSON TRANSFER (Hastings, Minnesota)
ROCK FALLS CHAMBER OF COMMERCE (Illinois)
ROCK HILL TELEPHONE COMPANY (Rock Hill, South Carolina)
ROCKAWAY BEACH CHAMBER OF COMMERCE (Rockaway Beach, Oregon)
ROCKDALE MEMORIAL COMPANY (Rockdale, Texas)
ROCKET RESEARCH COMPANY (Redmond, Washington)
ROCKY MOUNTAIN SHEET METAL CO. INC. (Casper, Wyoming)
RODGERS CONSTRUCTION COMPANY (Orange Park, Florida)
ROGERS & CLARK DISTRIBUTORS, INC. (Rochester, New York)
ROME SENTINEL COMPANY (Rome, New York)
ROME TURNEY RADIATOR COMPANY (Rome, New York)
ROMNEY CONCRETE COMPANY OF HAMPSHIRE COUNTY, INC. (Romney, West Virginia)
RONALD A. NAGY, DPM, P.C. (Mesa, Arizona)
ROOTLIEB, INC. (Turlock, California)
ROSE & ASSOCIATES (Bountiful, Utah)
ROSEVILLE CHRYSLER-PLYMOUTH, INC. (Roseville, Michigan)
ROSPATCH CORPORATION (Grand Rapids, Michigan)
ROW, INC. (Addison, Illinois)

ROY O. MARTIN LUMBER CO., INC. (Alexandria, Louisiana)
ROYAL INSULATION, INC. (Evanston, Wyoming)
RUPERT CHAMBER OF COMMERCE (Idaho)
RUSSELLVILLE CHAMBER OF COMMERCE (Arkansas)
RYDER SYSTEM, INC. (Miami, Florida)
RYE ACT SUPPLY (Rye, New York)
S & L MANUFACTURING CORPORATION (Ogema, Wisconsin)
S. GRUMBACHER & SON (York, Pennsylvania)
S. J. KENNEY CONSTRUCTION, INC. (Hardin, Montana)
S. RALPH CROSS & SONS, INC. (Worcester, Massachusetts)
S.C.R. MOLDING, INC. (Fullerton, California)
S.R. KOA CAMPGROUND (Moran, Wyoming)
S.W. INDUSTRIES LURGE (Dale, Indiana)
SAFETY ELECTRIC CONSTRUCTION COMPANY (Bridgeport, Connecticut)
SAFEWAY STORES, INC. (Oakland, California)
SAILBOAT SHOP (Austin, Texas)
SAINT MARY'S HEALTH CARE CORPORATION (Reno, Nevada)
SAINT MARY'S HOSPITAL (Rochester, Minnesota)
SAINT MARYS MEDICAL CENTER (Evansville, Indiana)
SALES TRAINING INSTITUTE (Bellevue, Washington)
SALINA ROOFING COMPANY (Salina, Texas)
SALTER'S HOME CENTER (Randolph, Vermont)
SAMMIE'S BBQ (Marlin, Texas)
SAMPSON LUMBER COMPANY INC. (Pembroke, Massachusetts)
SAN ANTONIO BRAKE AND CLUTCH SERVICE, INC. (San Antonio, Texas)
SAN FRANCISCO CHAMBER OF COMMERCE (San Francisco, California)
SAN JOSE CHAMBER OF COMMERCE (California)
SANFORD AUTO BODY SERVICE (Red Bank, New Jersey)
SCANDIC SPRINGS, INC. (San Leandro, California)
SCHWEBKE-SHISKIN & ASSOCIATES, INC. (Miami, Florida)
SCOTT PAPER COMPANY
SCN CORPORATION (Jackson Heights, New York)
SCOTT'S INC. (Grand Forks, North Dakota)
SCOTTIE'S AUTOBODY REPAIR, INC. (Hillsboro, Oregon)
SCOTTSBORO-JACKSON COUNTY CHAMBER OF COMMERCE (Alabama)
SEA SPORT CENTER, INC. (Ft. Walton, Beach, Florida)
SEABOARD ADJUSTMENT BUREAU, INC. (W. Babylon, New York)
SEARS & COMPANY, CPA'S (Atlanta, Georgia)
SECURITY STATE BANK (Hammond, Minnesota)
SEIDEL, INC. (San Angelo, Texas)
SELL'S BODY SHOP (Lebanon, Pennsylvania)
SENSORMATIC ELECTRONICS CORPORATION (Deerfield Beach, Florida)
SERVICE MASTER BUILDING MAINTENANCE (Lafayette, Louisiana)
SERVICE MASTER OF ALBERT LEA (Albert Lea, Minnesota)
SEVEN7-ELEVEN STORES, INC. (Westhampton, New York)
SHADOWBROOK RESORT (Tunkhannock, Pennsylvania)
SHANK KLEINEMAN DEZELAR ARCHITECTS (St. Paul, Minnesota)
SHAWNEE GARMENT MANUFACTURING COMPANY (Shawnee, Oklahoma)
SHERMAN IMP. LTD. (Seymour, Wisconsin)
SHERWOOD CAR WASH (Mesa, Arizona)
SHERWOOD SERVICE CENTER (Mesa, Arizona)
SHILOH OIL AND GAS COMPANY (Jackson, Mississippi)
SHOE WORLD (Corbin, Kentucky)

SHONEY'S INC. (Nashville, Tennessee)
SHOWS PIPE & SUPPLY INC. (La Grange, Texas)
SIDDALL'S T.V. (Attleboro, Massachusetts)
SIERRA AUTO BODY, INC. (Anaheim, California)
SIGN SHOP (Mesa, Arizona)
SILICONIX INCORPORATED (Santa Clara, California)
SIMCO PLATE GLASS, INC. (Ossining, New York)
SIMPSON-AHLBERG AUTO RENTAL (Roseville, Minnesota)
SIMS WHOLESALE COMPANY (Batesville, Arkansas)
PRESS PROMOTIONS INC. (Little Rock, Arkansas)
A & A MASONRY, INC. (Pittsburg, Texas)
SIRENA, INC. (South El Monte, California)
SISSON BUILDING SUPPLIES, INC. (North Tonawanga, New York)
SKIADAS BROTHERS ENTERPRISES (Coatesville, Pennsylvania)
SKILLS CENTER, INC. (Santa Cruz, California)
SKYVISION (Fergus Falls, Minnesota)
SLEEP STAR LIGHT MATTRESS COMPANY INC. (Batesville, Arkansas)
SLIGH FURNITURE COMPANY (Holland, Michigan)
SMALL BUSINESS COUNCIL OF AMERICA, INC.
SMITH OIL & TIRE (Springhill, Louisiana)
SMITH SURGICAL SUPPLY (Peoria, Illinois)
SMITH VILLAGE (Jacobus, Pennsylvania)
SMITTY'S GLASS & LOCK SERVICE (Albert Lea, Minnesota)
SNAP-ON TOOLS CORPORATION (Kenosha, Wisconsin)
SNYDER ENVIRONMENTAL (Shenandoah Junction, West Virginia)
SNYDER ENVIRONMENTAL SERVICES, INC. (Shenadoah, West Virginia)
SOCAL CONVERSIONS, INC. (Anaheim, California)
SOFTWARE CONSULTANTS, INC. (Eden Prairie, Minnesota)
SOILEAU INDUSTRIES (Villeplatte, Louisiana)
SON-RISE INC. (Lancaster, Massachusetts)
SONIC (Woodville, Texas)
SONITROL OF SAN JOSE, INC. (San Jose, California)
SORG DODGE, INC. (Goshen, Indiana)
SOUND & SERVICE (Carroll, Iowa)
SOUNDS EASY (Mesa, Arizona)
SOUTH BEND SUPPLY COMPANY, INC. (South Bend, Indiana)
SOUTH CARROLL BACKHOE INC. (Westminister, Maryland)
SOUTH FULTON CHAMBER OF COMMERCE (Georgia)
SOUTH SHORE CHAMBER OF COMMERCE (Massachusetts)
SOUTHEAST LOUISIANA HEALTH COST MANAGEMENT, INC. (New Orleans, Louisiana)
SOUTHEASTERN FIRE CONTROL, INC. (Atlanta, Georgia)
SOUTHEASTERN ROOFING & BUILDING SUPPLY, INC. (Cordele, Georgia)
SOUTHERN FOUNDRIES, INC. (Tyler, Texas)
SOUTHERN STATES COOPERATIVE, INC. (Richmond, Virginia)
SOUTHTRUST CORPORATION (Birmingham, Alabama)
SOUTHWESTERN CHURCH FIXTURE (Waxahachie, Texas)
SOUTHWESTERN CHURCH FURNITURE (Waxahachie, Texas)
SOUTHWESTERN MICHIGAN ABSTRACT & TITLE CO. (St. Joseph, Michigan)
SOUTHWESTERN PUBLIC SERVICE COMPANY (Amarillo, Texas)
SPACE AGE, INC. (Paramount, California)
SPARKS SPORT CENTER, INC. (Martinsbury, West Virginia)
SPEAKER & ASSOCIATES MANAGEMENT CORPORATION (Topeka, Kansas)
SPORTSPAGE RESTAURANT (Little Rock, Arkansas)
SPRING GREEN LAWN CARE (Leonardo, New Jersey)

SPRINGER ENVIRONMENTAL SERVICES, INC. (Acushnet, Massachusetts)
SPRINGFIELD PAPER COMPANY (Springfield, Missouri)
SPRINGVALE FARMS, INC. (Lisbon, New Hampshire)
ST. AMOUR & ST. AMOUR, INC. (Munising, Michigan)
ST. JOSEPH'S HOSPITAL AND MEDICAL CENTER (Phoenix, Arizona)
ST. MARY'S AREA CHAMBER OF COMMERCE (Ohio)
STAMPEDE CAMPER SHELLS, INC. (San Jose, California)
STAN'S AUTOMOTIVE SERVICE, INC. (Chula Vista, California)
STANDARD MOTOR PRODUCTS, INC. (New York, New York)
STANDARD REGISTER CO. (Dayton, Ohio)
STANDARD STEEL (Burnham, Pennsylvania)
STANDARD SUPPLY COMPANY (McAllen, Texas)
STANFORD'S HARDWARE CENTER, INC. (Kenner, Louisiana)
STANFORD'S TRUE VALUE HARDWARE (Kenner, Louisiana)
STAR SUPPLY (Terrell, Texas)
STARNES MECHANICAL (Huntsville, Alabama)
STATE FARM INSURANCE (Syracuse, New York)
STATE PARK GROCERY (Tyler, Texas)
STAYTON COOPERATIVE TELEPHONE COMPANY (Stayton, Oregon)
STEELE & WILLIAMS, INC. (San Antonio, Texas)
STEESES ICE CREAM & COUNTRY RESTAURANT (Grove City, Pennsylvania)
STEPHEN J. BECK M.D., P.A. (Longview, Texas)
STEPHENVILLE CHAMBER OF COMMERCE (Texas)
STERLING FOOD COMPANY (Burlington, Iowa)
STERLING HEIGHTS AREA CHAMBER OF COMMERCE (Michigan)
STEVIE'S PHILADELPHIA HOAGIE SHOP & DELICATESSEN (Pacific Grove, California)
STILLWATER NEWS PRESS (Stillwater, Oklahoma)
STM MASTER SEAL, INC. (Lebanan, Tennessee)
STOCKPOLE/ULTRA CARBON (Bay City, Michigan)
STOPBRAKE SHOPS #S (Bellflower, California)
STRUCTURAL COMPONENT SUPPLY CO. (Cannon Falls, Minnesota)
STUART C. IRBY COMPANY (Jackson, Mississippi)
SUBURBAN COMMERCIAL CLEANING (Royal Oak, Michigan)
SUBURBAN HARDWARE & FLOORING CENTER (Russellton, Pennsylvania)
SULPHUR SPRINGS TRUCK SERVICE (Sulphur Springs, Texas)
SUNCOAST BUSINESS PRODUCTS INC. (Ft. Walton, Florida)
SUNOCO EXPRESS U-HAUL (Endicott, New York)
SUNSET TERRACE HOMES (Henderson, Kentucky)
SUNTIDES MARKET (Yakima, Washington)
SUPER D DRUG (Sommerville, Tennessee)
SUPER SERVICE OIL COMPANY (Warwick, Rhode Island)
SUPREME CASTINGS & PATTERN CO. (Anaheim, California)
SYNBIOTICS CORPORATION (San Diego, California)
T-SHIRTS PLUS (Waco, Texas)
T.S.F. COMPANY, INC. (Evansville, Indiana)
TAHLEQUAH AREA CHAMBER OF COMMERCE (Oklahoma)
TAMMY'S FOODS, INC. (Fullerton, California)
TAX ADVICE (New Orleans, Louisiana)
TAYLOR MACHINE WORKS, INC. (Louisville, Mississippi)
TAYOR & FRIEND ENTERPRISES (Indianapolis, Indiana)
TAZE & HEWITT, INC. (Baltimore, Maryland)
TCI NORTHEAST, INC. (Pittsburgh, Pennsylvania)
TEACHING IDEAS PLANNING SYSTEMS (Charlottesvile, Virginia)
TEAGUE INDUSTRIES, INC. (Richardson, Texas)

TECHNICAL AID & DESIGN CO., INC. (Fraser, Michigan)
TECUMSEH BUILDING AND LOAN ASSOCIATION (Tecumseh, Nebraska)
TED VEHSLAGE SALES & SERVICE (Havana, Illionis)
TEGHTMEYER ACE HARDWARE (Syracuse, Indiana)
TELECOMMUNICATIONS TECHNOLOGY, INC. (Milpitas, California)
TERRE HAUTE AREA CHAMBER OF COMMERCE (Indiana)
TEXAS AGGIE BOOKSTORE (College Station, Texas)
TEXAS HOME HEALTH, INC. (Silsbee, Texas)
TEXAS WASTEWATER TREATMENT SYSTEMS, INC. (Burleson, Texas)
TEXOMA LUMBER COMPANY, INC. (Durant, Oklahoma)
TEXTILE RENTAL SERVICES ASSOCIATION
THE ANTHONY GALLUZZO CORPORATION (Derry, New Hampshire)
THE 4 WHEEL DRIVE CENTER OF MINNESOTA (Minneapolis, Minnesota)
THE APPLE TREE (Cameron, Texas)
THE ASSOCIATION OF THE WALL & CEILING INDUSTRIES - INTERNATIONAL
THE BECKMAN & GAST CO. (St. Henry, Ohio)
THE BRASS LANTERN (Adriani, Mississippi)
THE BRON-SHOE COMPANY (Columbus, Ohio)
THE BROOKINGS CLINC, P.A. (Brookings, South Dakota)
THE BYRNES GROUP (York, Pennsylvania)
THE C.H. TRIPLETT COMPANY (Pine Bluff, Arkansas)
THE C.R. CALVERT COMPANY, INC. (Kingman, Kansas)
THE CAFE (Little Rock, Arkansas)
THE CAMPBELL COLLABORATIVE (Phoenix, Arizona)
THE CINCINNATI GAS & ELECTRIC COMPANY (Cincinnati, Ohio)
THE CLUBHOUSE INC./DBA BABY FURNITURE (Charlottesville, Virginia)
THE COUNTY CHAMBER OF COMMERCE, INC. (Westchester County, New York)
THE DRAKE CO. OF SHREVEPORT, INC. (Shreveport, Louisiana)
THE EARLY WARNER COMPANY, INC. (Fairfield, California)
THE EASTERN COMPANY (Naugatuck, Connecticut)
THE EXTERMINATORS, INC. (York, Pennsylvania)
THE F & M BANK & TRUST COMPANY (Tulsa, Oklahoma)
THE FARMERS & MERCHANTS BANK (Stuttgart, Arkansas)
THE GRANADA RESORT (Lake Ozark, Missouri)
THE GREAT SURPLUS STORES, INC. (Winona, Minnesota)
THE GREATER SPRINGFIELD CHAMBER OF COMMERCE (Illinois)
THE HABITAT PET SHOP (Mesa, Arizona)
THE HALL CHEMICAL CO. (Wickliffe, Ohio)
THE J.S. PROCTOR COMPANY (Charlotte, North Carolina)
THE LANE COMPANY (Altavista, Virginia)
THE MADE-RITE CO. (Longview, Texas)
THE NU-YU BEAUTY SALON (Beverly Hills, Florida)
THE RESTAURANT ENTERPRISES GROUP, INC. (Irvine, California)
THE ROCKDALE REPORTER (Rockdale, Texas)
THE SHERWIN-WILLIAMS COMPANY (Cleveland, Ohio)
THE SIEMON CO. (Watertown, Connecticut)
THE STRIPPER (Rochester, Minnesota)
THE SWISS COLONY INC. (Monroe, Wisconsin)
THE TELEGRAPH PUBLISHING COMPANY (Nashua Telegraph)
THE TOLEDO EDISON COMPANY (Toledo, Ohio)
THE TURNER COMPANY (New York, New York)
THE UNIVERSITY OF TEXAS SYSTEM
THE WATERMILL, INC. (Yakima, Washington)

THE WATER WORKS (Boise, Idaho)
THE WEBLINE CORPORATION (Matthews, North Carolina)
THE WEST BEND COMPANY (West Bend, Wisconsin)
THE WEST CO., INC. (Phoenixville, Pennsylvania)
THE WOODLANDS DAY SCHOOL, INC. (Charlottesville, Virginia)
THIS SPUD'S FOR U, INC. (Little Rock, Arkansas)
THOMAS & BETTS CORPORATION (Raritan, New Jersey)
THOMPSON & MITCHELL (Washington, D.C.)
THREE CROWS CUSTOM FINISHES (Augusta, Georgia)
THREE J INDUSTRIES, INC. (Kilgore, Texas)
THREE M ASSOCIATES (Cumberland, Maryland)
TINKER MACHINING COMPANY, INC. (Linthicum, Maryland)
TODD VAN & STORAGE, INC. (Gaithersburg, Maryland)
TOM'S BODY WORKS (Belle Plaine, Minnesota)
TOP NOTCH DISTRIBUTORS, INC. (Honesdale, Pennsylvania)
TRACEY'S EXXON (Blue Ridge Smt., Pennsylvania)
TRADE LINES TRUCKING (Tyler, Texas)
TRAFFIC SYSTEMS, INC. (Tyler, Texas)
TRAM-TEX NUSERY, INC. (Tyler, Texas)
TRANSAMERICA DATA SYSTEMS (Litle Rock, Arkansas)
TRANSCO ENERGY COMPANY (Houston, Texas)
TRI CITY GLASS, INC. (Appleton, Wisconsin)
TRI-STATE DRYWALL COMPANY (Sioux City, Iowa)
TRIAD ASSOCIATES INSURANCE MARKETING SERVICES (Redding, California)
TRIANGLE MANUFACTURING CO., INC. (Upper Saddle River, New Jersey)
TROSKE MOTORS (Yakima, Washington)
TRU-STONE CORPORATION (Waite Park, Minnesota)
TRUCK HAVEN CAFES/SMITH INDUSTRIES (Sergeant Bluff, Iowa)
TRUMARK RUBBER STAMPS (Tyler, Texas)
TRUSSES, INC. (Billings, Montana)
TRUST DATA II (Oakland, California)
TURNER COACHES, INC. (Terre Haute, Indiana)
TURPIN & RATTAN ENGINEERS, INC. (Pasedena, California)
TWILIGHT HOME (Corsicana, Texas)
TWO2 WAY COMMUNICATIONS SERVICE, INC. (Portsmouth, New Hampshire)
TYLER AERO COMPANY, INC. (Tyler, Texas)
TYLER BOATS, INC. (Rockport, Indiana)
U-FRAME-IT OF FORT WALTON BEACH, INC. (Fort Walton Beach, Florida)
U.S. BUSINESS AND INDUSTRIAL COUNCIL
U.S. CHAMBER OF COMMERCE
UNIFOUR BUSINESS/MEDICAL COALITION (Hickory, North Carolina)
U.S. PIZZA COMPANY (Newport, Arkansas)
UDECO, INC. D/B/A COAST TO COAST STORE (Inver Grove Heights, Minnesota)
UMA ENTERPRISES INC. (Long Beach, California)
UNION TOWNSHIP CHAMBER OF COMMERCE (Ohio)
UNIQUE ALLOYS (Fullerton, California)
UNIT-PAK INC. (Waco, Texas)
UNITED AGRICULTURAL ASSOCIATION (Santa Ana, California)
UNITED CABARRUS INSURANCE AGENCIES, INCORPORATED (Kannapolis, North Carolina)
UNITED MACHINE SHOP INC. (Kilgore, Texas)
UNITED WELDING PROCESSES, INC. (Lynn, Massachusetts)
UNITY KNITTING MILLS, INC. (Wadesboro, North Carolina)
V.I.S. CONSULTANTS, INC. (Indianapolis, Indiana)

VACUUM'S UNLIMITED, INC. (Manchester, New Hampshire)
VAN OTIS CHOCOLATES, INC. (Manchester, New Hampshire)
VANDE VEN FARMS (St. Joseph, Louisiana)
VERNON'S OUTBOARD MOTOR REPAIR (Ville Platte, Louisiana)
VICKSBURG ANIMAL HOSPITAL (Vicksburg, Mississippi)
VICKSBURG-WARREN COUNTY CHAMBER OF COMMERCE (Mississippi)
VICTOR-BAWATA BELTING CO. (Easton, Pennsylvania)
VIDEO RITZ ON WHEELS (Middletown, New Jersey)
VIKING TOOL & ENGINEERING (Whitchall, Michigan)
VIMASCO CORPORATION (Nitro, West Virginia)
VINCE'S RED OWL (Litchfield, Minnesota)
VIRGINIA POWER COMPANY (Richmond, Virginia)
W.E. MORAN, INC. (Doraville, Georgia)
W.R. MALECKAR COMPANY (Minneapolis, Minnesota)
WACO EQUIPMENT COMPANY (West Yarmouth, Massachusetts)
WADE CONSTRUCTION CO., INC. (Sioux Falls, South Dakota)
WADES' WELDING (Emory, Texas)
WADSWORTH GOLF CONSTRUCTION COMPAY (Plainfield, Illinois)
WADSWORTH, INC. (Belmont, California)
WALL CONSTRUCTION COMPANY (Hendesson, Nebraska)
WALLOWA COUNTY CHAMBER OF COMMERCE (Oregon)
WARRICK, WEAVER & BOYR (Elkhart, Indiana)
WARRIOR SCREEN PRINTING (Tuscaloosa, Alabama)
WASHINGTON ELEVATOR CO., INC. (Washington, Michigan)
WASHINGTON NATURAL GAS COMPANY (Seattle, Washington)
WASTEX INDUSTRIES, INC. (Pottstown, Pennsylvania)
WATER EMPORIUM (Milpitas, California)
WATSON'S HARDWARE & PLUMBING (Hillsboro, Texas)
WAUKEGAN/LAKE COUNTY CHAMBER OF COMMERCE (Illinois)
WEAN INDUSTRIES, INC. (Youngstown, Ohio)
WEB SILVER CO., INC. (Philadelphia, Pennsylvania)
WEBB BUILDERS (Mount Pleasant, Arkansas)
WEBSTER CITY CHAMBER OF COMMERCE (Webster City, Iowa)
WELDEN BROTHERS, INC. (Iowa Falls, Iowa)
WELDON MACHINE TOOL, INC. (York, Pennsylvania)
WENATCHEE AREA CHAMBER OF COMMERCE (Washington)
WENOMA CORPORATION (Wenoma Lake, Indiana)
WEST COAST HEALTH CARE COALITION (Sarasota, Florida)
WEST HERNANDO CHAMBER OF COMMERCE (Florida)
WEST WHITTIER PAINT CO. (Whittier, California)
WESTERN BRICK & STONE, INC. (Spring Park, Minnesota)
WESTERN FARM BUREAU LIFE INSURANCE COMPANY (Denver, Colorado)
WESTERN RANCH SUPPLY (Billings, Montana)
WESTERN SHEET METAL & ROOFING CO., INC. (Cheyenne, Wyoming)
WESTINGHOUSE ELECTRIC CO. (Pittsburgh, Pennsylvania)
WESTPHALIAN PROVISION CO., INC. (Yonkers, New York)
WESTPOINT PEPPERELL (Dalton, Georgia)
WETTERAU INCORPORATED (Hazlewood, Missouri)
WGA INSURANCE SERVICES (Newport Beach, California)
WHATCOM TIRE CENTER, INC. (Ferndale, Washington)
WHEATLAND PROPERTY ANAGEMENT (Topeka, Kansas)
WHEATLEY GRADING CONTRACTORS, INC. (Martinez, Georgia)
WHITE RIVER LANES (Batesville, Arkansas)

WHITFIELD NURSING HOME, INC. (Corinth, Mississippi)
WICHITA FEDERAL SAVINGS & LOAN ASSOCIATION (Wichita, Kansas)
WICHITA INDEPENDENT BUSINESS ASSOCIATION (Wichita, Kansas)
WILDISH CONSTRUCTION COMPANY (Eugene, Oregon)
WILLEY ENTERPRISES, INC. (Belton, Missouri)
WILLIAM A. DOUGHERTY ASSOCIATES, INC. (Rochester, New York)
WILLIAM D. NEALE, D.D.S. (Ft. Walton Beach, Florida)
WILLIAM DIERDORF & SONS, INC. (West Paterson, New Jersey)
WILLIAM STONE, D.D.S. (Longview, Texas)
WILLIAMS COMPANY (Ennis, Texas)
WILLIAMS ELECTRIC (Waco, Texas)
WILLIAMS INSTRUMENT COMPANY, INC. (Valencia, California)
WILLIAMS PAINT & BODY (Daingerfield, Texas)
WILLIAMS SERVICE COMPANY (York, Pennsylvania)
WILLIAMS SOUND CORPORATION (Minnetonka, Minnesota)
WILLMAR AERIAL SPRAYING, INC. (Olivia, Minnesota)
WILSON DRSE HDW. (Monroe, Louisiana)
WILSON PALLET, INC (Smyrna, Delaware)
WILSON SUPPLY COMPANY (Albert Lea, Minnesota)
WING DRUG CO., INC. (Marshfield, Wisconsin)
WINNSBORO-FRANKLIN PARISH CHAMBER OF COMMERCE (Louisiana)
WINONA MONUMENT COMPANY (Winona, Minnesota)
WINTER PARK CHAMBER OF COMMERCE (Winter Park, Florida)
WINTER YACHT BASIN INC. (Mantoloking, New Jersey)
WISCO INDUSTRIES, INC. (Oregon, Wisconsin)
WISCONSIN - UP STIHL, INC. (Haywood, Wisconsin)
WISCONSIN GRINDING SERVICE, INC. (Milwaukee, Wisconsin)
WOLF'S BAR-B-Q, Inc. Evansville, Indiana)
WOLTER & RAAK, LTD. (St. Charles, Minnesota)
WONDER BOWL, INC. (San Antonio, Texas)
WOOD CHEMICAL SANITARY MAINTENTANCE SUPPLY (Victoria, Texas)
WOODLAWN CORPORATION (Gaithersburg, Maryland)
WOODRUFF DOOR CO., INC. (Batavia, New York)
WOODWARD GOVERNOR COMPANY (Rockford, Illinois)
WOOLFOLK'S BBQ (Henderson, Kentucky)
WORDEN SPECIALTIES (Tyler, Texas)
WORDEN'S WORLD OF CRAFTS, INC. (Pompano Beach, Florida)
WORDTEMPS, INC. (Dallas, Texas)
WORLD CAVALCADE (Seattle, Washington)
WORTHWEST FEDERAL BANKING & SAVINGS (New Richmond, Wisconsin)
WYATT ASSOCIATES, INC. (Thorsby, Alabama)
WYOMING CHAMBER OF COMMERCE (Wyoming, Michigan)
XIDEX CORPORATION (Santa Clara, California)
YAKIMA STEEL FABRICATORS, INC. (Yakima, Washington)
YORK AREA CHAMBER OF COMMERCE (York, Pennsylvania)
YORK CANDIES, INC. (York, Pennsylvania)
YORK COUNTY BLIND CENTER (York, Pennsylvania)
YORK LINCOLN MERCURY CO. (York, Pennsylvania)
YOUNG C. BOWLDEN PALLET REPAIR & SALES (Hateville, Georgia)
YOUNGSTOWN AREA CHAMBER OF COMMERCE (Ohio)
ZABOKRTSKY'S HARDWARE (Washington, Kansas)
ZERO ZONE REFRIGERATOR MANUFACTURING (Waukesha, Wisconsin)
ZILLMER ELECTRIC (Waukesha, Wisconsin)

Statement of
Michael Roark, Vice President of Human Resources
WestPoint Pepperell
On Behalf of
The National Association of Manufacturers
On
Access to Health Care for Uninsured Workers
Before the
Senate Committee on Labor and Human Resources
November 4, 1987

We are pleased to have this opportunity to submit this statement on the subject of access to health care for uninsured workers, an issue of great concern to the NAM and WestPoint Pepperell. We agree with senators who have observed that those employers not protecting their employees raise costs for the rest of us. We believe, however, that mandates are not the solution and that mandates which are overly specific and inflexible may have results harmful to both the national economy and those workers already protected by employer health care plans.

EMPLOYMENT AND HEALTH INSURANCE COVERAGE

The majority of Americans obtain health insurance through employer based plans. In 1985, corporations spent over $105 billion to insure 130 million persons. If the $22 billion cost of Medicare payroll taxes is added, this represents a commitment of $127 billion to insure the medical well-being of workers and their dependents. These costs doubled between 1979 and 1985.

Despite these enormous costs, 75 percent of all workers are covered by an employer-sponsored health care plan and 97 percent of full-time workers employed by companies with 250 or more employees are covered by such plans.

While this is undeniably a success story, the fact is that at varying times during the year, 30 to 37 million Americans are without health insurance coverage. Data from the March 1986 Current Population Survey (CPS) conducted by the U.S. Census Bureau, reports that 24 million working adults did not have employer, union or other group-based health insurance. Seven million purchased their own insurance leaving some 17 million uncovered. Fifty-six percent are 18 to 24 years old. Although the private sector employs almost two-thirds, 1.8 million uninsured workers are employed by federal, state or local government. On the earnings side, about 12.3 million or half of the uncovered workers, had weekly earnings below $150 in 1985 and another eight million had wages averaging $150 to $400 per week.

We as concerned citizens and you as members of this committee may well ask why so many employed persons are without health insurance. Many are low-wage workers employed by very small and often marginally viable firms. In fact, only 39 percent of those firms with fewer than 25 employees offer health insurance.

Another group includes part-time employees variably defined as those working anywhere from 10 to 30 hours a week. The Pillsbury Company, which operates Burger King, Steak and Ale and Bennigans restaurants, employ a large diverse part-time workforce and provide health insurance based on individual need. For example, Burger King employees, whose average age is 18-20, prefer to work part-time, and often are students covered by family plans. Eligibility for insurance requires six months on the job and completion of at least 1,000 hours per year. Steak and Ale employees have an option of purchasing health insurance. Out of 30.000 eligible persons. only 6.000 have chosen to purchase coverage. Although Pillsbury prefers to hire full-time employees given the high costs of hiring. few individuals desire full-time work. a major factor shaping benefit policy in this industry. This preference for full-time workers is based upon costs associated with training. paperwork for payroll processing and compliance with federal and state tax requirements.

One third of uninsured workers have incomes below the poverty level. Medicaid. the federal/state health care program for the poor. covers fewer than 40 percent of those persons living below the poverty line and because 31 states require income of less than 50 percent of the poverty level for Medicaid eligibility. few working people. even if low-paid. can qualify.

PUBLIC CONCERN FOR THE UNINSURED

The number of uninsured between 1982 and 1984 rose nearly 15 percent. While jobs increased during this period. growth was mainly in smaller firms and in industries that have not traditionally offered employer-sponsored benefits. Cost-consciousness on the part of both government and the private sector has reduced the amount of uncompensated care that can be shifted to private-paying patients. Declining public health budgets have also had their impact and given large federal deficits Congress is reluctant to enact new public entitlement programs.

Experience With COBRA. Given this reluctance. efforts (and that includes S. 1265) are underway to shift some of the responsibility to the private sector. Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) passed in 1985. requires continuation health insurance coverage for certain classes of beneficiaries. Although COBRA became effective January 1. 1987 for most employer plans, early indications already show adverse impact, particularly on small employers.

Watco Manufacturing Company. a firm of 30 employees in Kansas City. Missouri. learned in early January that an employee had terminal cancer. Following employment termination in July. this former employee requested COBRA continuation. Meanwhile. the insurance carrier raised rates. so much so. that the company is considering dropping insurance and raising compensation to permit workers to purchase individual coverage.

Similarly, Acousticom Corp., a firm of 56 employees in Elkhart, IN, was hit with a 55 percent increase in its insurance rates and sought to change carriers. Responding carriers all refused to pick-up COBRA continuees. Acousticom is also considering terminating its insurance coverage.

POTENTIAL IMPACT OF S. 1265

Legislation introduced on May 21 by Senators Kennedy (D-MA) and Weicker (R-CT) would require all employers of ten or more workers to provide health benefits to employees and their dependents. As I stated earlier, we believe that this legislation, while well-intentioned, would be harmful to the national economy and to individual Americans, in that it would result in lost jobs, lost exports, and the loss of that ability which we as employers now enjoy, to tailor our benefits programs to the priorities of the men and women who staff our mills, factories, and offices.

The Congress is faced with a dilemma. On the one hand are at least 30 million Americans lacking a basic level of health protection; on the other a federal deficit which virtually precludes new spending initiatives. Legislation transferring social costs to private industry is a seductive alternative which allegedly appears to do much good and little harm.

This might be true if mandated benefits were nothing more than a hidden tax on the American people, if it were just another cost of doing business to be added to the price of our goods in the marketplace. The realities are different. We do business in a global economy and many employers are at the limits of their ability to raise prices. Today, employee benefits add 34.6 percent to the average hourly wage of American workers. By comparison, such benefits add 21 percent to the wages of a Korean worker, 16.8 percent to the wages of a Japanese worker and 5 percent to the wages of a Taiwanese worker. If we legislate significant increases in the cost of making a garment in Georgia or South Carolina, that garment will be made in Taiwan or South Korea next year. In summary, the proposed mandate will raise manufacturing costs and diminish American competitive strength in the global marketplace.

Effect on Group Medical Plans. If this legislation is enacted, group medical plan expenditures, according to Business Insurance magazine (9/7/87), could increase 24 to 70 percent, relative to the employer's contributions for dependent coverage. For example, a company now contributing 90 percent for employees and 25 percent for dependents could expect a 55 percent increase in costs. Cost increases would vary according to employer contributions for workers and dependents.

A survey (9/87) of 70 companies conducted by Towers, Perrin, Forster and Crosby found that not one company met benefit requirements of S. 1265. Companies surveyed included health care organizations with part-time workers, banking/diversified financial companies, industrial organizations with less than and greater than 1,000 employees and retail organizations, all of whom employ part-time workers. These employer health plans failed to meet the proposed bill requirements for such reasons as lack of coverage for persons working less than 17 1/2 hours per week; lack of free coverage for lowest paid; exclusion for pre-existing conditions; and contributions for dependent coverage that exceeded 20 percent of premium. Thirty-five percent of respondants indicated they would stop hiring part-time workers or reduce part-time hours.

The bill sets 20 percent of the monthly cost as the maximum employee contribution to coverage. In the textile and apparel industries it has long been common practice for the employer to pay 100 percent of the cost of the employee's coverage and to require the employee to pay between 30 percent and 100 percent of the cost of dependent coverage. For WestPoint Pepperell, with 32,000 employees, the nation's second largest publicly held textile manufacturer, the 20 percent limitation on employee contributions would add $3.4 million per year to costs. Put another way, for WestPoint Pepperell this would represent the manufacture and profitable sale of approximately 25 million towels.

Small Firms. For smaller manufacturers with less generous plans, the cost would be proportionally greater. Their response to mandates may also be more dramatic. Increased costs for required benefits may cause some companies to cutback other benefits, reduce staff, or go out of business entirely. Though some small firms may not themselves trade overseas, they are often suppliers to large companies who do so. Mandates could prevent small firms from entering overseas markets altogether.

Eligibility Requirements. Coverage under S. 1265 must commence after 30 days on the job. The U.S. Bureau of Labor Statistics in its 1985 survey of medium to large companies found that only 19 percent of manufacturing companies extended coverage after 30 days. In 22 percent of manufacturing companies, coverage was not extended until the worker had completed three months on the job. Eligibility for health benefits varies across industries for many reasons, most predominantly the degree to which the industry is labor intensive and subject to high turnover in the early months of employment. In our view it is unwise to impose one national model on a diversity of businesses. WestPoint Pepperell, following the custom of our industry, requires three months for eligibility. The 30 day requirement of S. 1265 would add $1 million per year to our costs despite the fact that since new employees coming to a job are likely to have coverage under COBRA this requirement is largely redundant.

Cost Containment and Employer Flexibility. As mentioned earlier, S. 1265 as drafted, would increase the cost of American manufactured goods; decrease our ability to competitively price those goods in the world marketplace and inevitably cost American jobs. Our second objection to the bill is that it may deprive us of that flexibility which we now enjoy, and from which our employees benefit, to design plans responsive to the perceived needs of our employees and their expressed priorities. This same flexibility has enabled us to respond to changes in medical science and in the system of health care delivery with innovative plan provisions which contain costs without compromising patient care.

Corporate America has seen employer health costs more than double from $51.3 billion in 1979 to $105.6 billion in 1985. Strategies for dealing with this inflationary trend include pre-certification for hospital admissions, second opinions for elective surgery, waiver of deductibles and co-payments for patients who have minor surgery performed as out-patients in lieu of hospital admission, and employee audits of hospital bills. How would S. 1265 regard financial penalties on employees for failure to obtain pre-certification? Would employers be required to eliminate such features to comply with the law?

Today, hernia corrections, cataract removals, tonsillectimies and many types of knee surgery, are routinely performed in surgical centers on an out-patient basis. A few years ago these procedures would have required expensive hospitilization. These changes in medical practice have come about largely at the insistence of corporate insurers who demanded cost containment. How, in the future, do we demand cost-effective medical practice if any change in plan provisions requires either a bureaucratic imprimatur or an act of Congress?

The amount of money available for employee benefits in labor intensive industries is finite. To the extent that certain benefits are mandated, an employer's ability to offer other benefits is circumscribed. While the WestPoint Pepperell plan would have to be amended in a number of costly ways to comply with S. 1265, our plan also contains numerous provisions such as dental coverage, prescription drug coverage, coverage for alcohol and drug rehabilitation and psychiatric coverage which are not required by the bill. These provisions have been added in response to the expressed preferences of our employees. To the extent that mandated benefits limit flexibility in plan design, those employee preferences may become irrelevant.

The prohibition under S. 1265 of the application of deductibles and co-payments to pre-natal and well-baby care, violates the most basic principles of cost-effective plan design and could increase the cost experience of virtually every comprehensive health care plan in American industry. As a practical matter, it seems unwise to single out these benefits given the varied nature of households today.

Flexible Benefits. Now offered by 29 percent of the Fortune 1000 companies, flexible benefits represent another area for concern. While most such plans require employees to accept a minimal health benefit or demonstrate proof of coverage outside the plan, many flexible health plans would not meet the standards of S. 1265. Philosophically, these plans recognize that all workers are not the sole breadwinner of a family consisting of a spouse and two children. A young single employee may wish to accept a $1,000 health-care deductible in exchange for increased vacation time. S. 1265 mandates a $250 maximum deductible. Flexible benefits have become an increasingly popular tool for attracting and retaining employees.

Small firms are also adopting flexible benefits. Master Chemical Corporation, for example, with 150 employees in Perrysville, Ohio, offers core benefits which include medical, disability, and life insurance and a retirement plan. In addition, employees are given a flexible spending account and can choose from a menu including expanded medical coverage, child care and a 401(k) savings plan.

UNINSURED WORKERS: ALTERNATIVES FOR HEALTH INSURANCE COVERAGE

We believe that the solution to the problem of the working uninsured lies not in mandates which endanger both American jobs and the flexibility of the private insurance system. but in an approach involving the selected restructuring of public programs and the encouragement of initiatives already underway to put cost-effective private insurance within the reach of small employers. In this connection we would suggest the following areas for increased attention.

Medically Uninsurable. According to the Health Insurance Association of America. approximately one million persons are considered medically uninsurable. meaning that these individuals have been rejected or significantly restricted in their ability to qualify for employer-sponsored or individually purchased insurance. To assist the medically uninsured. encourage states to establish pooling arrangements; set reasonable premiums with shortfalls financed through the use of general revenues. Plan design should provide basic coverage and include utilization controls to encourage cost-consciousness.

Medicaid. Less than 40 percent of the poor are covered by Medicaid. down from two-thirds a decade ago. Minimum federal standards for Medicaid eligibility. irrespective of family or employment status or place of residence are needed. Kentucky and Tennessee. for example. have eligibility levels at 35 percent and 25 percent of the poverty level for a family of four. To alleviate this problem. establish minimum federal standards for Medicaid at 100 percent of poverty to enable low-paid workers to continue in the labor force and decrease reliance on welfare; Medicaid should be returned to its original role in funding health care for low-income persons. Evolving solutions to finance long-term care should in time decrease the burden on Medicaid now used to pay for much of this care.

Establish a Medicaid buy-in arrangement to provide low-paid workers access to health insurance. To control costs. consider development of basic coverage plans. utilization controls. managed care systems and other means to make care affordable. Develop shared financing arrangements for Medicaid buy-ins with participation by government. employers and employees. For employers. phase-in contributions tied to corporate profitability. The employee share should be scaled to income with a full Medicaid phase-out at twice poverty.

State Actions. In addition to Medicaid. some 34 states operate indigent care programs targeted at such groups as young children and pregnant mothers. Eleven states operate risk pools to help the medically uninsurable purchase insurance. Hospitals serving high numbers of indigents receive earmarked funds for serving the uninsured. Another approach, used by Massachussetts and New Jersey, regulates all hospital rates and includes a portion to finance uncovered care.

Through a variety of efforts, states are serving the uninsured and have done so without federal statutes. Because state efforts recognize local needs, they are in a better position of fashioning responses targeted to the specific problem.

NAM Initiatives. The NAM encourages its member companies to provide employee health coverage whenever and wherever it is practical to do so. We support the development of cost-effective group health insurance vehicles for small businesses and the use of managed systems for providing indigent health care. We also support tax incentives for the self-employed to offer health benefits to their workers and demonstration grants on cost-effective health insurance for small firms.

Basic Plans. For firms which are unable to afford more comprehensive protection, we believe basic low cost catastrophic plans should be developed. For part-time workers, pro-rate premiums between employer and employee relative to the number of hours worked per week. To keep premiums reasonable, the plan design should be directed at meeting truely unbudgetable health care expenses. High deductibles and co-payments are important as well as the exclusion of dental, vision and hearing benefits. The exemption from state benefit mandates is also important to keep coverage affordable. The NAM is currently working with several insurers to develop a prototype plan and would be glad to share this information with the Committee when it becomes available.

Group Purchasing. Small firms working together are demonstrating the advantages of group purchasing of insurance. The Council on Smaller Enterprises, a division of the Greater Cleveland Growth Association, provides health insurance to over 4,500 small companies representing approximately 45,000 employees and with dependents serves some 100,000 persons providing administrative management for low cost health insurance. Of these companies, 75 percent have less than ten employees. The Council has been successful because it offers administrative efficiency, financial power, negotiating power, and greatly increased flexibility, all of which stem from the collective clout of working together.

The Wisconsin Association of Manufacturers and Commerce, a NAM state affiliate, representing 3,000 businesses, 44 percent of whom have less than 50 employees, formed a business coalition in Milwaukee to pool purchasing of health insurance.

WAMC is also working with the state legislature on a voucher proposal for uncovered health care and designing a data system to produce uniform and timely hospital utilization information.

Robert Wood Johnson Foundation Grants. The Robert Wood Johnson Foundation has funded fifteen grants to encourage the development of health insurance for small firms with particular emphasis on low wage earners. The Florida Department of Health and Rehabilitative Services is developing a Multiple Employer Trust (MET) targeted at small firms with ten employees or less and include a disproportionate number of low income workers. To keep insurance premiums affordable, a number of cost saving mechanisms are being used, including a preferred provider organization and use of a gatekeeper or primary care physician. United Way of Bay Area, San Francisco is studying the feasibility of a health information brokering service to address the needs of small employers in obtaining health insurance coverage. An inventory of health plans serving small employers is expected to help such firms surmount this information barrier. Replicating these and similar efforts can do much to encourage insurance coverage at minimal cost without impairing employment.

CONCLUSION

The problem of providing access to health care for uninsured workers and their dependents is a serious social issue demanding the attention of this committee and all segments of society. We do not, however, believe that it is either necessary or desirable to tinker with an efficient system of employer-provided insurance which is working very well for 130 million Americans, in order to provide access to health care for the minority who are uninsured. S. 1265 may meet the short-term goal of access to care, but long-term it will result in complex federal regulations, increased costs of goods and services, the loss of jobs, diminished capacity to compete in global markets, limitations on employee choice of benefits, and an escalation of the cost of health care even beyond what can currently be projected.

The NAM pledges its cooperation to work with the Committee in seeking solutions on access to health care for uninsured workers. We thank you for this opportunity to include our views in the record.

Leading the Foodservice/Hospitality Industry

311 FIRST STREET, N.W., WASHINGTON, DC 20001 202/638-6100 FAX: 202/347-2989

NATIONAL
RESTAURANT
ASSOCIATION

November 3, 1987

The Honorable Orrin G. Hatch
SR 135
U.S. Senate
Washington, DC 20510

Dear Senator Hatch:

This is in further regard to our recent correspondence in opposition to S. 1265, the Minimum Health Benefits for All Workers Act. The National Restaurant Association, which is the leading trade association for the foodservice industry would like you to feel free to express our opposition to this costly and onerous legislation at the hearing tomorrow. Please be assured that we will file comments on its impact on our membership in the near future and hope to have the opportunity to testify at a future date.

Our diverse membership is made up of tableservice restaurants, fast food outlets and cafeterias, as well as operations that provide foodservice for institutions such as hospitals, universities and military clubs. With over 600,000 establishments, the U.S. foodservice industry employs 8 million workers, or about 7 percent of the nation's workforce. In 1987, our industry will contribute $197.5 billion to the United States Gross National Product.

The National Restaurant Association believes that the problem of gaps in health care coverage for Americans is something that warrants a great deal of consideration; however, we feel that the broad approach of S. 1265 is the wrong one.

The question must be asked why certain employers do not provide health care for their employees. The answer is a simple one; they cannot afford it. By mandating that employers who are operating on a shoestring provide health care with estimated premiums of $1,200 for individuals and $2,892 for families (estimates provided by the Institute of Research on the

Economics of Taxation, IRET) will only result in a reduction in the workforce, as well as a reduction in working hours and possible bankruptcies for many small businesses. IRET also estimates that the legislation will increase private insurance costs by $100 billion the first year and will lead to a $35 billion loss in federal income and social security tax revenues due to the decreases in salaries and hours. These reductions will hurt employees at the low end of the pay scale most because the cost of the insurance would be such a sizeable percentage of their compensation. For example, an employee making $3.50/hour that works 17 1/2 hours a week makes $3,062.50 a year before taxes. If an employer has to pay for even an individual insurance premium of $1,200, it would represent 39% of the employee's income. In addition, S. 1265 would force businesses to cut back on entry-level positions, only fueling unemployment and pushing more Americans onto the welfare rolls.

We at the National Restaurant Association will continue to oppose the intervention of the federal government into the private decision-making process. We do, however, encourage you to continue to explore other legislative proposals that will make it easier for employers to provide health care for their employees and look forward to working with you and your staff. As we know only too well, mandates will only end up hurting those the Congress has been trying to help.

We hope that you will feel free to contact us if we can be of assistance and we thank you for being such a friend to our industry.

Sincerely,

Ronald A. Sarasin
Director, Government Relations

STATEMENT OF THE NATIONAL RESTAURANT ASSOCIATION ON THE MINIMUM HEALTH BENEFITS FOR ALL WORKERS ACT, S. 1265 BEFORE THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

NOVEMBER 4, 1987

The National Restaurant Association appreciates this opportunity to present its views regarding the Minimum Health Benefits for All Workers Act, S. 1265. We are the leading trade association for the U.S. foodservice industry, representing tableservice restaurants, fast food outlets and cafeterias, and institutional feeders such as hospitals, universities and military clubs.

With over 600,000 establishments, the foodservice industry employs 8 million workers, or about 7 percent of the nation's work force. In 1987, the industry will contribute $197.5 billion to the U.S. GNP.

Our industry is aware that there are gaps in the existing private health insurance system, and we agree that in an ideal world universal access to health insurance is a worthy goal. But our members must operate in the real world, and we do not consider the broad-brush approach of S. 1265 to be a realistic solution to the problem of uninsured workers. To force all American businesses to provide health care benefits, regardless of the cost and without thoroughly reviewing all of the consequences, will in the long run only hurt those this committee is trying to help.

Restaurants and other industries dominated by small businesses* would bear the heaviest burden if S. 1265 were enacted. With lower profits, less stability and greater employee turnover than their larger counterparts, small businesses would be least able to offer the benefit package required under the bill. And their employees, who generally receive lower wages and are more apt to work part-time, would also lose, since the high cost of compliance would leave many employers with no choice but to reduce the hours of their least productive employees.

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* Seventy percent of all foodservice operations have sales of less than $500,000 per year.

The very characteristics that have made restaurants and other small businesses such a dynamic economic force and the source of millions of entry-level jobs also make them especially sensitive to labor cost increases a bill like S. 1265 would cause. The restaurant business is a very labor-intensive one, and our industry employs large numbers of young, inexperienced and part-time workers, many of whom would otherwise be without a job. We employ more teenagers than any other industry, and we have the shortest average workweek (approximately 26 hours) of any industry.

Many of these employees are only marginally attached to the work force. They may be students with part-time jobs, mothers who work to bring extra income into the household, or retirees who wish to continue to be productive but don't want a full-time job. They are essential to our operations, but most of our members cannot afford to provide them with the array of benefits required under S. 1265.

For small independent restaurateurs already faced with high payroll costs, the additional expense of providing comprehensive health benefits to all employees--without regard to their level of productivity--is simply prohibitive. It is hard enough for restaurateurs to provide even a bare-bones health plan, but complying with S. 1265 would mean enormous new costs. The requirement that employers pay 100 percent of the premiums for employees receiving less than $4.19 an hour and the fact that many part-time employees (those working as few as 17.5 hours a week) would qualify for full benefits are, in our judgment, the ingredients for bankruptcy and disemployment.

A study by the Institute for Research on the Economics of Taxation (IRET) estimates the net result of the bill "would be a million fewer jobs in the economy than would otherwise occur and a major change in composition of virtually every worker's compensation package." It is not difficult to see why this would happen. According to IRET, to justify the added labor costs due to a mandated insurance package, a minimum wage foodservice worker, for example, would have to demonstrate an immediate 17 percent increase in productivity. The prevalence of part-time foodservice jobs only compounds these costs, since, for all intents and purposes, this bill treats part-time and full-time workers alike--all would receive full benefits regardless of their relative productivity.

In the end, the real losers under this proposal are the very employees it is designed to help. By raising the cost of labor, S. 1265 puts a higher price on the head of America's least productive, lowest-skilled workers. Those with the least to offer--those lacking job experience or those with lower education achievements--would be the first to feel the disemployment effects of this proposal. Our industry would be particularly hard-hit, because we provide many of these individuals with their first job experience.

Even if an employee isn't laid off as a result of S. 1265, he still may suffer economically. The bill removes the choice that is the hallmark of a free market system and forces adult employees to participate in their employer's health care plan regardless of whether they need or can afford the coverage. S. 1265 would not require teenagers to accept coverage if they are included on their parents' plan, but if they are paid less than $4.19 an hour they may very well opt for coverage, since it would not cost them a cent under the bill. The added cost of such unnecessary coverage would have the effect of driving up health care costs and ultimately raising employer payroll costs.

Several months ago we asked some of our members to estimate how much it would cost them to comply with S. 1265. The chart on the next page shows the cost of compliance for a cross-section of companies, ranging from a large national restaurant chain to smaller independent foodservice companies. Note that for most of these companies, health care costs would at least double under S. 1265, and for some, costs would increase five to sevenfold!

Our sampling indicates that even companies that already provide health care benefits would incur significant dollar increases under

Company	Full-time employees*	Current annual health care costs	Cost with S. 1265 premiums**	Cost with IRET premiums***
A	40	$ 0	$ 33,696	$ 61,104
B	52	35,000	41,337	66,163
C	81	26,877	68,782	124,966
D	175,000	39,700,000	149,210,000	276,000,000

* Employees working 17.5 hours a week or more.
** Estimated premiums by the Actuarial Research Corporation for Senator Kennedy. $642/individual, $1,631/family.
*** Estimated premiums by the Institute for Research on the Economics of Taxation (IRET). $1,200/individual, $2,892/family.

the legislation. Our findings also suggest the Congressional Budget Office (CBO) erred in assuming for the purposes of its study that "no existing employment-based policy would have to be improved to meet the specified standards of MHB, either by offering broader benefits or by increasing the employer's contribution." IRET has estimated that the federal government alone would have to spend an additional $2.4 billion to bring its health care plans into compliance with S. 1265.

The CBO analysis is correct, however, when it concludes that employers would respond to S. 1265 by lowering wages, reducing employee hours or even laying off employees--demonstrating that there is an obvious cause and effect between increasing benefit requirements and an employer's ability to meet payroll costs.

CBO also says that businesses might decide to pass on the higher benefit costs to consumers, or they might absorb the costs by lowering their profit margins. But for restaurants, these are not alternatives. Our industry is highly competitive, and there is a limit to the amount of increased labor costs we can pass on to our customers. Restaurants compete not only with each other, but also with at-home food preparation. In the restaurant industry, passing on costs can be the economic equivalent of suicide. And when many restaurants barely turn a profit in even the best of times, squeezing profit margins is not an option either. For many, the only way to absorb labor cost increases is to eliminate jobs or curtail employee hours. Some operators might even resort to replacing full-time workers with two or more part-time employees so they can avoid coverage under this proposal.

Of course, many of our members do provide health care benefits to their employees. According to the Census Bureau, over 50 percent of all food preparation and service workers are covered by an employer or union-provided group health plan. Employers know that in order to attract and keep a loyal and stable work force, they must offer a good benefits package. As small firms grow and become more profitable, they add to their compensation plans, and health insurance is generally one of the first benefits they offer. A study by the Bureau of Labor Statistics shows that by the time a company has 100 employees, it will have added health care coverage in almost all cases.

But for many small employers, a comprehensive health care package is out of reach. Not only are these businesses less profitable, less stable and more apt to have high employee turnover--all factors that deter them from establishing health benefits--but they are getting the short end of the stick in the current health insurance arena.

The Small Business Administration (SBA) reports that health care costs are up to 40 percent higher for small firms. Both sales and administrative costs are higher, and just one high-cost case may damage an employer's rating. Even at equal levels of profitability, SBA says small firms are less able to pay for health insurance than large firms given that small businesses are more likely to be sole proprietorships--with limited tax deductibility of health insurance costs. In addition, small businesses employ most of the young and old in the work force, further adding to administrative costs and threatening stability for rating purposes.

S. 1265 attempts to address some of these problems, but a mandate from Washington does not suddenly make health insurance affordable for small businesses and their employees. We are not convinced the provisions designed to help small businesses, such as the establishment of regional health care providers, would be in the best interest of any company--large or small. These provisions would only have the effect of restricting competition, thus creating health care monopolies and driving up costs.

A far better approach is for Congress to identify and facilitate the underlying economic factors that lead a business to provide health insurance to its employees. The private sector should not be bullied, but rather encouraged--through tax credits and other incentives--to provide health insurance to its employees. Congress can solve the problem of the uninsured worker, but only if it is willing to work with the private sector to develop a fair and flexible solution. Higher benefit costs, lower productivity and widespread unemployment are too high a price to pay when other, more efficient solutions are at hand. We are willing to help the committee find these solutions, provided these solutions take into account the individual circumstances of businesses and their employees and do not result in a counterproductive mandate from Washington.

NATIONAL ASSOCIATION OF WHOLESALER-DISTRIBUTORS

STATEMENT OF

NATIONAL ASSOCIATION OF WHOLESALER-DISTRIBUTORS

BEFORE THE

Senate Labor & Human Resources Committee
U.S. Senate

ON

S.1265, MINIMUM HEALTH BENEFITS FOR
ALL WORKERS ACT
NOVEMBER 16, 1987

1725 K Street N.W. Suite 710 • Washington, D.C. 20006 • 202/872-0885 • FAX 202/785-0586

SUMMARY

The National Association of Wholesaler-Distributors (NAW), is a federation of 124 national, 50 state and regional associations and 3,000 individual wholesale distribution companies. All told, NAW represents some 45,000 companies and over 150,000 places of business across the country.

NAW is also Executive Secretariat for the Concerned Alliance of Responsible Employers (CARE) a coalition of 160 corporations and trade associations actively seeking to preserve the rights of employers and employees to determine which benefits are best suited to their individual and mutual needs.

Wholesale distribution is a labor-intensive industry. As a result, employee benefits constitute a significant portion of a wholesaler-distributor's cost of doing business. Employers within the wholesale distribution industry offer a wide range of benefits -- including health insurance -- which are designed to attract and retain a qualified and productive workforce. In the wholesale distribution industry alone, a recent survey indicates that 98 percent offer health insurance to full-time employees.

NAW is unequivocably opposed to S.1265 for both policy and practical reasons. S.1265 would require a change in the design of most employer-provided health insurance plans, impose burdensome federal verification requirements on employers, and reduce other forms of compensation for employees.

S.1265 would add to the already exorbitant inflation rate for medical care, thereby increasing employers' costs of providing health insurance.

Perhaps most importantly, it is dangerous public policy to require the private sector to provide a specific employee benefit as a cost of doing business. Businesses are far more capable that the government of weighing the advantages and disadvantages of various employee benefits. Saddling the labor market with obligations too expensive and burdensome for its participants to choose voluntarily will seriously undermine employment opportunities and business growth. Additionally, it will restrict the freedom of choice workers and managers now enjoy to develop and implement compensation packages best suited to individual needs.

The National Association of Wholesaler-Distributors strongly urges the members of this committee to defeat S.1265.

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I. THE NATIONAL ASSOCIATION OF WHOLESALER-DISTRIBUTORS AND THE WHOLESALE DISTRIBUTION INDUSTRY

The National Association of Wholesaler-Distributors is a federation of 124 national (list attached,) 50 state and regional trade associations, as well as 3,000 individual wholesale distribution companies. All told, NAW's membership collectively includes some 45,000 companies and 150,000 places of business across the country.

NAW's membership ranges from very small to very large businesses and is responsible for over 60 percent of the $1.4 trillion of merchandise which flows through wholesale channels annually. NAW members also employ a comparable percentage, or 3 million, of the 5 million Americans who work in the wholesale distribution trade.

II. NAW AND ITS MEMBERS HAVE A SUBSTANTIAL INTEREST IN MANDATED BENEFIT LEGISLATION

Wholesale distribution businesses are labor-intensive and employee wages and benefits constitute a significant portion of a wholesaler-distributor's cost of doing business. As a result, individual wholesale distribution businesses and the National Association of Wholesaler-Distributors on behalf of its members have an on-going and substantial interest in any federal legislation which would mandate the benefit package provided by employers to their employees.

Given its substantial interest in any legislation mandating employee benefits, NAW co-founded the Concerned Alliance of Responsible Employers (C.A.R.E.). NAW also serves as Executive Secretariat of C.A.R.E., which was formed in December, 1986 by major trade associations and corporations actively seeking to preserve the rights of employers and employees to determine which benefits are best suited to their individual and mutual needs.

CARE's growing membership currently is comprised of approximately 160 corporate and trade association members which directly represent the manufacturing and service sectors, wholesaler-distributors, the food and restaurant industry, personnel administrators and hundreds of thousands of small, mid-size, and large firms across the country.

For its part, the National Association of Wholesaler-Distributors is unalterably opposed to S.1265, the Minimum Health Benefits for All Workers Act, for reasons grounded in policy and preacticalty which are detailed below.

III. S.1265 WOULD REQUIRE A DRASTIC ALTERATION OF EMPLOYER-PROVIDED HEALTH INSURANCE PLANS

A recent survey conducted by NAW of wholesale distribution firms indicated that 98 percent of 1300 respondents provide some type of health insurance coverage to full-time employees.

S.1265 would set specific health insurance coverage levels for all workers employed for 17½ hours per week or more, require no premium payment by those earning less than $4.18 per hour and no deductible for prenatal or well baby care. Even the most generous employer-provided health insurance plans do not pay 100 percent of pre-natal and well baby care, and do not base employee premium payments on salary. Therefore, even those companies, including a vast majority of wholesaler-distributors, who provide standard or above-standard health insurance coverage would be forced to revamp their entire health benefit system to comply with a new federal requirement. This is just one example, in NAW's view, which does little to address the underlying purpose of S.1265 --to mandate health insurance for workers not presently covered.

IV. NEW FEDERAL REQUIREMENTS IMPOSED BY S.1265 WOULD INCREASE EMPLOYER COSTS AND REDUCE OTHER FORMS OF COMPENSATION

Although cost estimates vary, there is no doubt that S.1265 will in fact impose additional costs on the private sector employer. In order to simply "break even," employers will logically reduce other forms of compensation , some of which may actually be preferable by employers to what is proscribed by S.1265. For example, in order to meet the specific requirements of S.1265, employers may reduce or eliminate dental, psychological, drug dependency and alcoholism rehabilitation care.

More critically, the employment opportunities for lower paid workers could be altogehter eliminated as the cost of hiring those workers increases. Part-time employees working more than 17½ hours per week will undoubtedly see a reduction in their work hours. Additionally, forcing low-income workers to pay 20 percent of a health insurance premium is a far greater burden than for those at the higher income scale. Therefore, S.1265 clearly represents a regressive payroll tax, hurting, again, those it most seeks to help.

V. S.1265 WOULD ADD TO INFLATION RATE FOR MEDICAL CARE

The rising costs of American health care has become a national problem. While the annual inflation rate for goods and services has increased 110.6 percent since 1960, the inflation rate for medical care has increased 800 percent during the same time period. S.1265, while increasing the cost of medical insurance for employer and employee alike, does nothing to address the escalating costs of medical care. In fact, S.1265 would exacerbate the problem by creating a higher demand for medical care which would cause a subsequent rise in prices. According to the Institute For Research on the Economics of Taxation:

> . . . During the post-World War II period, only 50 cents of each dollar, in medical expenditures has yielded an increase in the quantity of medical services produced

> The other 50 cents has simply increased the rate of medical inflation . . . The price increase due to the higher medical care utilization of the newly insured would be more than double any hope for savings on uncompensated care.

The higher cost of medical care will obviously translate into a higher premium cost for medical insurance, thus adding further to the burden of the private sector employer and employee.

VI. FEDERALLY MANDATING BENEFITS IS DANGEROUS PUBLIC POLICY

When a benefit like health insurance is statutorily mandated, the ability to respond on an evolving basis is circumscribed. Congress can, of course, weigh in later and change the law. The question then becomes whether Congress, as a matter of fact, and relative efficiency, is the party best able to make such decisions. NAW submits that the answer is a resounding "No."

It is dangerous public policy to require the private sector to provide a specific employee benefit as a cost of doing business.

Businesses are far more capable than the government of weighing the advantages and disadvantages of various employee benefits and of responding in a timely manner to the changes in needs and circumstances. The overall level of compensation is determined by the marketplace and firms wanting to attract and retain good workers will meet marketplace demands. Saddling the labor market with obligations too expensive and burdensome for its participants to choose voluntarily will simply undermine employment opportunity and growth. Congress should look at employer-provided health insurance -- which insures 85 percent of the 191 million privately insured Americans -- as a practically "full glass." Business would not have provided the bulk of America's health care if it did not make sense for it to do so. Why penalize these businesses through enactment of this legislation?

VII. CONCLUSION

Flexibility is the key to the success of private employers' benefits policy. It is essential that this flexibility remain in the future so that employers can continue to respond to the changing needs of their workforce.

Mandated benefits are not the answer. Requirements such as those contained in S.1265 will only increase the cost of doing business, reduce U.S. productivity and further jeopardize our nation's competitiveness posture.

National Wholesaler-Distributor Organizations Affiliated with the National Association of Wholesaler-Distributors

Air-conditioning & Refrigeration Wholesalers
American Jewelry Marketing Association
American Machine Tool Distributors Association
American Supply Association
American Traffic Safety Services Associaiton, Inc.
American Veterinary Distributors Association
Appliance Parts Distributors Association, Inc.
Associated Equipment Distributors
Association of Footwear Distributors
Association of Steel Distributors
Association of the Wall and Ceiling Industries-International
Automotive Service Industry Association
Aviation Distributors & Manufacturers Association

Bearing Specialists Association
Beauty & Barber Supply Institute, Inc.
Bicycle Wholesale Distributors Association, Inc.
Biscuit & Cracker Distributors Association

Ceramic Tile Distributors Association
Cooper & Brass Servicenter Association
Council for Periodical Distributors Association
Council of Wholesale-Distributors National Kitchen & Bath Association

Door & Hardware Institute

Electrical-Electronics Materials Distributors Assn.
Engine Service Association
Explosive Distributors Association, Inc.

Farm Equipment Wholesalers Association
Fire Suppression Systems Association
Fluid Power Distributors Association, Inc.
Food Industries Suppliers Association
Foodservice Equipment Distributors Association

General Merchandise Distributors Council
Graphic Arts & Equipment Supply Dealers

Health Industry Distributors Association
Hobby Industry Association of America

Independent Medical Distributors Association
Institutional & Service Textile Distributors Association, Inc.
International Sanitary Supply Association
International Truck Parts Association
Irrigation Association

Jewelry Industry Distributors Association

Machinery Dealers National Association
Material Handling Equipment Distributors Association
Motorcycle Industry Council
Music Distributors Association

National-American Wholesale Grocers' Association
National Appliance Parts Suppliers Association
National Association for Hose & Accessories Distributors
National Association of Aluminum Distributors
National Association of Chemical Distributors
National Association of Container Distributors
National Association of Decorative Fabric Distributors
National Association of Electrical Distributors
National Association of Fire Equipment Distributors
National Association of Floor Covering Distributors
National Association of Flour Distributors
National Association of Manufacturing Opticians
National Association of Marine Services, Inc.
National Association of Meat Purveyors
National Association of Plastics Distributors
National Association of Service Merchandising
National Association of Sporting Goods Wholesalers
National Association of Tobacco Distributors
National Association of Writing Instrument Distributors
National Beer Wholesalers Association
National Building Material Distributors Association
National Business Forms Association
National Candy Wholesalers Association
National Commercial Refrigeration Sales Association
National Electronic Distributors Association
National Fastener Distributors Association
National Food Distributors Association
National Frozen Food Association
National Grocers Association
National Independent Poultry and Food Distributors Association
National Industrial Belting Association
National Industrial Glove Distributors Association
National Insulation Contractors Association
National Lawn & Garden Distributors Association
National Locksmith Suppliers Association
National Marine Distributors Association
National Paint Distributors, Inc.
National Paper Trade Associaton, Inc.
National Plastercraft Association
National Sash & Door Jobbers Association
National School Supply & Equipment Association
National Solid Wastes Management Association
National & Southern Industrial Distributors Associations
National Spa and Pool Institute
National Truck Equipment Association
National Welding Supply Association
National Wheel & Rim Association
National Wholesale Druggists' Association
National Wholesale Furniture Association
National Wholesale Hardware Association
North American Heating & Airconditioning Wholesalers
North American Wholesale Lumber Association, Inc.

Optical Laboratories Association
Outdoor Power Equipment Distributors Association

Pet Industry Distributors Association
Petroleum Equipment Institute
Petroleum Marketers Association of America
Power Transmission Distributors Association, Inc.

Safety Equipment Distributors Association, Inc.
Scaffold Industry Association
Security Equipment Industry Association
Shoe Service Institute of America
Specialty Tools & Fasteners Distributors Association
Spring Service Association
Steel Service Center Institute

Textile Care Allied Trades Association
Toy Wholesalers' Association of America

United Pesticide Formulators & Distributors Association

Video Software Dealers Association

Wallcovering Distributors Association
Warehouse Distributors Assocaition for Leisure & Mobile Products
Water and Sewer Distributors Association
Wholesale Florists & Florist Suppliers of America
Wholesale Stationers' Association, Inc.
Wine & Spirits Wholesalers of America, Inc.
Woodworking Machinery Importers Association
Woodworking Machinery Distributors Association

NATIONAL ASSOCIATION OF WHOLESALER-DISTRIBUTORS
1725 K Street, N.W., Washington, D.C. 20006 • 202/872-0885

10/87

STATEMENT OF GARY W. GROVE
VICE PRESIDENT - CORPORATE BENEFITS
MARRIOTT CORPORATION
TO THE SENATE LABOR AND HUMAN RESOURCES COMMITTEE
NOVEMBER 4, 1987 - A HEARING ON S.1265

I am Gary W. Grove, Vice President - Corporate Benefits at the Marriott Corporation. I would like to discuss our major concerns with S.1265, the Minimum Health Benefits for all Workers Act of 1987. First, I am concerned with S.1265 as it affects Marriott Corporation. Second, I am also concerned as S.1265 affects all employee (labor) intensive companies in which the net profit margins are very slim. Third, I am especially concerned with the enormous impact of this proposal on smaller businesses. Out of these concerns, I hope the Senate Labor and Human Resources Committee will reconsider the scope, costs and timing associated with S.1265.

At Marriott, the direct economic impact of S.1265 would more than triple the costs of medical coverage for employees. In relative terms, the cost increase attributable to S.1265 equates to one half of the total net profit of the company. The major reasons for such a devastating impact are --

- a mandate to all full time employees to enroll for coverage;
- a definition of full time as 17 1/2 hours per week;
- a mandate for employers to pay 80% of cost;
- a mandate for employers to pay 100% of cost for low wage workers and no pre-existing conditions limitations.

Proposals that may soften the impact would include provisions which would --

- allow a long-term phase-in for all mandated benefits;
- allow employees to opt out of employer coverage by certifying they are covered by another group or private plan (covered employees should not be required by law to change their coverage -- in many instances to lower benefits);
- define full time initially at 30 hours per week with a reduction to 27 1/2 hours two years later and to 25 hours two more years later (employer responsibility to full time employees is clearly different than the responsibility to part time, temporary or seasonal employees);
- phase-in employer cost at 50% level for employees, increasing by 10% in years 1, 3 and 5 after legislative effective date;
- remove responsibility for cost of dependent coverage from employers (whether employees have children or non-working spouses is their own decision and family responsibilities should not be transferred to employers); and
- allow reasonable pre-existing conditions limitations of at least one year of employment for coverage so businesses with traditional high levels of turnover not

under employer control will not incur major additional and uncontrollable costs.

Companies in our situation when faced with such alarming cost increases will be required to --

- o either combine jobs which reduces overall employment, or manage a large number of workers to work less than the mandated threshold level;
- o reduce benefit coverage levels for all employees thereby shifting major costs and coverage reductions to employees who are presently covered;
- o target hiring of employees without dependents; and
- o manage cost avoidance in creative ways as yet unknown but with the certain result of lowering coverage levels.

In a broader context, providing medical coverage for every working American and their dependents will create new demand for medical services at a time when medical costs are escalating as a percentage of GNP. Something must be done to have a "brake" in the system on potentially runaway costs. One possible "brake" would be to eliminate coordination of benefit (COB) provisions and include in the legislation a new provision that a person can only be covered by one policy -- similar to current rules on fire insurance.

The bill should also allow individuals to select from alternative policies in order not to negate the positive impact of co-payments and deductibles whose objective is to impose a sense of shared responsibility.

In summation, the Marriott Corporation has never ignored the needs and larger interests of its employees. We are a public company, but in many ways we still consider ourselves to be what we were from our outset - a family-run business. Today, we are one of the largest employers in the U.S. This brings with it an even greater acknowledgement on our part of our responsibilities to the well being of our work-force. We have a reputation held by our own employees that we are going to put all of our efforts into providing a safe and worthwhile workplace for them. Still, we cannot support a mandated system of benefits. It represents a government intrusion into our business that we believe is not in anyone's best interest - especially our employees' interest. As I noted above, the net result of a mandate will likely diminish and erode the benefits our employees now enjoy.

My comments, therefore, on the scope, costs and timing of S.1265 and the suggested alternatives thereto should not be misconstrued as support for a mandate. Rather, these comments must be read in the context of our broader opposition to such a mandate as a matter of fundamental principle for the workplace.

Small
Business
Legislative
Council®

November 2, 1987

Honorable Orrin G. Hatch
Ranking Minority Member
Committee on Labor and Human Resources
United States Senate
SD-428 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Hatch:

Enclosed please find our statement on S. 1265, "The Minimum Health Benefits For All Workers Act of 1987." Would you ensure that it is placed in the record for the hearing on November 4, 1987 of the Committee on Labor and Human Resources.

The Small Business Legislative Council is firmly opposed to S. 1265. The potential impact on small business is significant and adverse. We fear that legislation such as this will halt or reverse the job creation trend in small business. In recent years small business has consistently out-performed the remainder of the economy in this regard and to reverse the process would have serious ramifications for the economy.

We hope Congress will take a long and careful look at this legislation.

Sincerely,

John S. Satagaj
President

JSS/0285
Enclosure

Small
Business
Legislative
Council®

Statement of the

SMALL BUSINESS LEGISLATIVE COUNCIL

Before the

Committee on Labor and Human Resources
United States Senate

November 4, 1987

S. 1265, "The Minimum Health Benefits
For All Workers Act of 1987"

On behalf of the Small Business Legislative Council (SBLC), we wish to express our strong opposition to S. 1265, the Minimum Health Benefits For All Workers Act of 1987. While the issue of health insurance coverage for all Americans is a very real concern, we do not believe this legislation offers a realistic alternative. We believe that philosophically, conceptually and technically, it is flawed.

The Small Business Legislative Council (SBLC) is a permanent, independent coalition of over ninety trade and professional associations that share a common commitment to the future of small business. Our members represent the interests of over four million small businesses in manufacturing, retailing, distribution, professional and technical services, construction and agriculture. A list of our members is attached.

It has been generally accepted that there is a pool of some 32 million persons uninsured in this country. Approximately 17 million are non-workers and approximately 3.7 million are laid off or are looking for work. The remainder are uninsured workers. The Office of Advocacy of the U.S. Small Business Administration estimates that 6 million workers uninsured workers are employed by small business. In addition, 1.6 million sole proprietors are uninsured. On the other hand, the "The State of Small Business" June, 1987, prepared by the Office of Advocacy, reports that: "Health care expenditures in 1950 represented only 4.4 percent of Gross National Product; by 1985, at $425 billion, they accounted for almost 11 percent. The share of gross payroll spent by employers for health benefits increased by as much as 50 percent between 1976 and 1983. In 1986, health care costs averaged 8 percent of payroll, for an employer outlay of $1,460 per employee." S. 1265 proposes to solve the problem of the uninsured by further exacerbating the problems created by the escalating costs of health care for employees.

This legislation mandates that all small businesses, regardless of size, will be required to provide a minimum level of health insurance to all employees and dependents. The bill requires the employer to provide a plan which covers all medically necessary hospital care, physician care, diagnostic tests, and prenatal and well-baby care. The plan must provide catastrophic protection against serious illness, with a cut-off of $3,000 in out-of-pocket expenses.

The bill also limits deductibles to $250 a person and $500 a family, and it limits co-payments from employees to 20 percent of the cost of any service. The bill would require the employer to provide coverage for all full-time employees, defined as employees working a minimum of 17 and 1/2 hours per week.

The bill does allow employers the opportunity to modify the coverage to meet special needs of their employees, so long as the overall value of the plan is not cut back. It also permits businesses less than two years old to provide only the catastrophic protection for their workers.

Finally, the bill does provide for the certification of regional insurance carriers that will provide insurance to any small business. Small businesses, without insurance upon enactment of the law, must use the regional carrier and any small business, desiring to make a future change, must use the regional carrier. As well intentioned as it may be in its goals, we cannot support such legislation.

First, we believe this legislation is philosophically misguided. The Federal government should not interfere in the relationship between employer and employee. The fact is, in a small business, each employee is an integral part of the overall successful operation of the business. A small business is truly dependent on its employees and flexibility is important in the small employer/employee relationship. For the truly innovative, growing sector of the small business economy-the job creators-skilled labor is an increasingly important consideration. Businesses, however, should be left alone to conduct the "business of doing business."

Second, this legislation is built upon a foundation of unrealistic assumptions. It has been suggested by some that small business owners make a willful choice not to offer health insurance to their employees; their intent is to maximize profit. In most cases if the employees do not have coverage neither does the owner. The reality is that most small business owners simply cannot afford coverage. The cost of coverage is significant to a firm with only a modest profit and a labor intensive business. If Congress mandates benefits, how will small business pay for these benefits? You cannot mandate profitability. The recent "State of Small Business Report," published by the Office of Advocacy, indicates business failures increased by 7.4 percent in 1986 and bankruptcies increased by 12.8 percent. It appears implausible to us that businesses, which this bill will most directly affect, are hiding profits that could be allocated to health care coverage.

One actuarial estimate was provided upon introduction of this bill. It suggests the cost of coverage would be roughly $64 per month per employee. We do not believe the cost will be anywhere as low as that estimate or current actual costs. The bill assumes that legislating absolute demand will lower the cost of coverage. Such an assumption is based on a belief there will be an incentive for suppliers to compete. First, a captive market, by definition, removes some of the incentive to compete. Only vigorous and rigorous antitrust enforcement can prevent the formation of a cartel. Even this assumes, of course, that there is an opportunity for any competition in the market. Under the proposal, the government would certify regional carriers to provide insurance to those employers that cannot secure coverage through conventional means. The proposal, however, also requires that any employer of twenty-five or fewer employees, which does not have coverage on the day this law is enacted, _must_ obtain coverage from a regional carrier. Any employer that wishes to or must change carriers after the law is enacted _must_ use the regional carrier. We believe the creation of the regional carrier system and the mandatory participation requirements virtually lock out private sector competition. We understand why the regional carriers concept was proposed--in the hope it would ensure the availability of coverage for those firms not able to purchase the coverage elsewhere and to provide economies of scale to lower costs. We understand why the requirement for mandatory participation in the regional carrier program was proposed--in the hope it would ensure an adequate mix of insured companies. We understand the motivation for the regional carrier and the mandatory requirement but we do not believe they will achieve these objectives.

While the drafters of this legislation were constructing ways that will theoretically provide coverage at reasonable cost we believe they failed to recognize the downside of the equation. What or who is going to ensure that the regional carriers will price their product at a reasonable level? We can easily envision the need for constant Federal supervision of the process--a new bureaucracy. Worse yet, a regional carrier saddled with marginal firms will soon be back to the government for a handout. Long term Federal government financial assistance to these carriers is only around the corner.

There are further fallacies in the regional carrier concept, described by one insurance industry source as follows:

> Administrative and marketing expenses almost certainly would exceed 13% and claim costs--the level assumed by the preliminary estimate. Regional insurers would continue to incur marketing expenses to increase their share of the small employer market. Although scale economies could lower some expenses for regional insurers, most of the administrative costs in this market are due to the employers' small size and not the insurers' volume. Regional insurers would continue to experience higher costs caused by the nature of small business, such as high employee turnover, and limited in-house benefits administration. Finally, allowing only a few insurers to market coverage in each region could lead to less, rather than more, competitive pricing.
>
> Adverse selection in the regional pools will lead to higher than expected premiums for small employers. Regardless of size, employers with poor experience would choose pool coverage if their experience-rated premium exceeded the community rate. At the same time, employers in low-cost areas within regions will be able to obtain lower premiums than the regional community rate and remain outside of the pool. The lack of underwriting or waiting periods, combined with the community rate, also would lead to the formation of groups for the sole purpose of obtaining coverage. Indeed, it could encourage the "hiring" of friends and relatives who already are ill and unable to obtain coverage at standard rates to give them access to inexpensive coverage.
>
> Finally, the estimates do not include adjustments for claims incurred by employees of firms that fail to pay premiums. These unpaid premium costs already lead to higher expenses in the small employer market and requiring marginal firms to purchase health benefits could increase this cost.

It is ironic to us that the bill will discourage those who have worked hardest to provide coverage for employers--associations--from continuing their efforts. Many associations provide or sponsor insurance programs for their members. The programs work because they provide coverage for those very small businesses. If all businesses joining the association that either do not have coverage or currently have coverage with another carrier are precluding from joining the association's plan, as it appears they will be under the bill, it is only a matter of time before those association sponsored or operated programs fail.

We have conducted surveys of our member associations and appended to this statement are copies of four industry profiles; one in retailing, two in distribution, and one in light manufacturing. The results are not surprising. The smallest firms tend not to provide coverage and these firms are found predominantly in the retail and service sectors. We found costs to range upward to $150 a month per employee or more. This, of course, is significantly higher than the actuarial estimate provided at the introduction of this bill. Further, the legislation would require employers to provide coverage for employees and their dependents. Throughout this statement we cite estimates for coverage for workers only. The cost of dependent care will greatly exacerbate the difficulties small firms would have if required to provide coverage. Also, we found that the scope of coverage currently provided is less than that provided for by the bill. Thus, the net result of our survey is that we believe the cost will be anywhere from a third more to twice the cost of current coverage for most employers.

Our data, overall, is consistent with the data included in the recently released "State of Small Business Report". An entire chapter, "Health Care Coverage and Costs in Small and Large Business," is devoted to this issue in the report. For example, the SBA study indicates that only 32 percent of retailers are likely to offer coverage. Florists' Transworld Delivery Association, the retail association whose study is appended, indicated 35 percent of their members provide insurance. As the SBA study noted, "Small retail firms are, in general, less profitable, less stable, not unionized and have frequent employee turnover--all factors that deter employers from establishing health benefits. Because these firms are labor-intensive, any added payroll costs affect them disproportionately and may be harder to absorb than in a capital intensive larger company." For these firms if the premium is $140, $85 or "just" the "$64" per month, it is will be a dramatic and devastating increase. While we are convinced that increases for small employers with plans are crippling; for those who must comply and provide insurance coverage for the first time, this legislation virtually guarantees a crisis in the business. We are sure that throughout the course of this debate there will be much discussion about the aggregate cost of this proposal. While we are concerned about such costs, we believe that the per company cost of compliance should be a principal concern.

How do small businesses view this proposal? Question thirteen of our survey posed that question to the business owner. The responses, which are included in the appended surveys, make for revealing reading. The terms lay-offs and wage cuts appear frequently. The small business community will be forced to react in the only way it can to survive, with cutbacks that will hurt the very individuals this legislation hopes to help. In February, 1987, at SBLC's annual conference, our membership ranked our priorities for 1987-88. The number one priority, by a wide margin, was:

> There should be no government mandated employee benefits. Rather, Congress and the states should explore creative alternatives for the private sector, including tax favorable incentives for encouraging the provision/expansion of employer-sponsored health care and other employee benefits.
>
> The Small Business Legislative Council supports the following actions:
>
> 1. Rejection of any type of mandated benefits.
>
> 2. Equalization of self-insured and fully insured health plans with respect to existing mandated benefits.
>
> 3. Exploration of alternatives that retain a voluntary flexible benefits system and at the same time enable employees to fulfill their job and family responsibilities.

Small businesses are less likely than large businesses to provide employees with health and other fringe benefits, primarily because of relatively higher funding and administrative costs. Mandated benefits impose additional costs and are likely to widen further the gap between large and small businesses.

For almost a decade the states have been imposing hundreds of requirements on commercial health plans. The laws vary from state to state, but generally pertain to three areas: inclusion of specific services, such as mental health care; coverage of certain providers, such as chiropractors; and coverage of certain individuals, e.g., widows, who may purchase health insurance at group rates through the employer.

Under the Employee Retirement and Income Security Act of 1974 (ERISA), the Federal government is responsible for regulating self-insured plans. This distinction is important because while most small employers use traditional health insurance and therefore must pay for mandated benefits, the majority of large employers are self-insured and not subject to these state requirements.

Recently the Federal government has turned to the employer and has imposed mandates similar to those passed by the states. The first Federally mandated health benefit was included in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Employers with

> twenty or more employees with an employer-sponsored health plan are required to offer coverage to divorced spouses, widows, certain dependents, and employees terminated for any reason short of gross misconduct.
>
> Other proposals introduced include: continuation of the employer's contribution for laid-off employees for four months; mandated family and medical leave, including continued health insurance during a worker's absence; and the establishment of state risk pools, with the pool's losses financed by an employer tax. Proposed legislation would typically disallow an employer's present health care tax deduction unless a particular benefit was provided, or specified group covered.

This recommendation is consistent with the concerns of the delegates to the White House Conference on Small Business held in August, 1986. The delegates to that conference voted the following recommendation as their number two priority:

> There should be no government mandated employee benefits, such as employer-paid health benefits, parental leave, disability leave, etc. Specific actions should include, but not be limited to, the following:
>
> a. Congress should prohibit the states from mandating employee benefits.
>
> b. Congress should reject parental and disability leave legislation, such as H.R. 4300 and S. 2278.
>
> c. Congress should reject proposals to mandate medical coverage. Business supports creative efforts in the private sector to identify new and voluntary approaches to enable working parents to fulfill their job and family responsibilities.
> Small business is united in its concern regarding this legislation.

We hope you will not stifle the job creation efforts that the small business community has provided in our economy. For these reasons we must strongly oppose S. 1265. Thank you.

SURVEY CONDUCTED

by

Florists' Transworld Delivery Association

The florist delivery cooperative was founded in 1910, and today includes more than 23,000 independent florists throughout North America. The association's sales during the 1985-86 fiscal year totaled more than $596 million. Florists of FTD delivered over 21.9 million orders during the 12-month period. Outside North America, FTD is part of Interflora, Inc., a worldwide flowers-by-wire organization which now includes 52,000 florists in 127 countries. FTD's 350-person headquarters staff is based in Southfield, MI.

SPECIAL RESEARCH REPORT

RESEARCH DEPARTMENT

Prepared By: Holly Hissong Research Department
Report Number: 87-40 Date:
Prepared For: Management

HEALTH INSURANCE COVERAGE SURVEY

HEALTH INSURANCE COVERAGE SURVEY

BACKGROUND/METHODOLOGY

The Small Business Legislative Council, a policy group of 90 small business trade associations, recently asked FTD to administer a questionnaire that would help evaluate the impact of currently pending legislation which, if passed, would make it mandatory for employers to provide health care coverage to employees and their dependents.

The proposed law (S.1255 by Senator Ted Kennedy, D-Mass, and H.R.2508 by Representative Henry Waxman, R-Calif) would require florists to provide hospital and doctors' care and catastrophic health insurance among other mandatory benefits. The employer would pay at least 80% of premiums and 100% for low-wage employees. Low-wage employees are described as those earning up to 125% of the federal minimum wage.

To allow FTD Members a chance to express their views concerning this legislation, FTD conducted the survey among its U.S. Members. The questionnaire, included in this report, was mailed in conjunction with the June 8th FTD Member Newsletter. By the survey deadline, June 30, 2,981 FTD Members had returned completed questionnaires. Tabulated results, as provided in this report, were forwarded to Hill & Knowlton in Washington, D.C., to be used in evaluation of the proposed bills.

HEALTH INSURANCE COVERAGE SURVEY

SUMMARY OF FINDINGS

- Only 35.5% of the 2,981 FTD Members surveyed currently provide health coverage for their employees, (re: Table 1).
- Only 17.6% of total respondents provide health coverage for their employees' dependents, (re: Table 2).
- Average monthly premiums are estimated at $150 or less for most respondents who offer coverage, (re: Table 3).
- Average monthly premiums per family are estimated to range between $101 and $250, (re: Table 4).
- Most Members who do offer health coverage plans pay between 41% and 100% of the premium, (re: Table 5).
- 13% of Members providing coverage advise that they have no deductible per employee. The remainder generally pay between $91 and $250 as a deductible, (re: Table 6).
- 12.4% of those providing family health coverage pay no deductible per family, while the others generally pay $151 or over, (re: Table 7).
- The total monthly insurance payments incurred by Members' business varies greatly from shop to shop, (re: Table 8).
- Most respondents providing insurance (87.4%) advise that their plan includes both hospitalization/surgical and major medical, (re: Table 9).
- Insured employees per shop range from 1 to 6, (re: Table 10).
- Most shops providing employee health coverage have 1 to 4 part-time employees, each working at least 17½ hours per week, (re: Table 11).
- Additional benefits offered by Members offering insurance include paid vacation (averaging 1.6 weeks per year), life insurance and paid holidays, (re: Table 12).
- If required to provide health insurance coverage to all employees, 28.8% of total respondents foresee adverse effects on their business and 10.1% feel that they would be forced to close their shop(s). Other responses are listed in Table 13.

DETAILED TABLES

TABLE 1

PROVISION OF HEALTH COVERAGE FOR EMPLOYEES

QUESTION: DO YOU PROVIDE HEALTH COVERAGE FOR YOUR EMPLOYEES?

MAIN RESPONSES	TOTAL (%)
• No	63.6%
• Yes	35.5
• No response	0.9
BASE: Total respondents	(2,981)

TABLE 2

PROVISION OF HEALTH COVERAGE FOR EMPLOYEES' DEPENDENTS

QUESTION: DO YOU PROVIDE HEALTH COVERAGE FOR YOUR EMPLOYEES' DEPENDENTS?

MAIN RESPONSES	TOTAL (%)
• No	80.5%
• Yes	17.6
• No response	1.9
BASE: Total respondents	(2,981)

TABLE 3

AVERAGE MONTHLY PREMIUM PER EMPLOYEE

QUESTION: WHAT IS THE AVERAGE PREMIUM PER EMPLOYEE PER MONTH?

PREMIUM RANGES	TOTAL (%)
• $50 or less	15.6%
• $51 - $100	53.5
• $101 - $150	10.5
• $151 - $200	1.5
• $201 - $250	0.9
• $251 - $300	0.6
• $301 - $350	0.2
• $351 - $400	—
• $401 - $450	—
• $451 - $500	0.1
• $501 - $550	0.1
• $551 - $600	0.1
• $601 - $650	—
• $651 - $700	—
• $701 - $750	0.2
• $751 - $800	—
• $801 - $850	—
• $851 - $900	—
• $901 - $950	—
• $951 - $1,000	0.1
• $1,001 & over	0.1
• Amount varies	0.4
• Don't know/uncertain	0.1
• No response	16.0
BASE: Respondents who provide health coverage for their employees	(1,057)

TABLE 4

AVERAGE MONTHLY PREMIUM PER FAMILY

QUESTION: WHAT IS THE AVERAGE PREMIUM PER FAMILY PER MONTH?

PREMIUM RANGES	TOTAL (%)
• $50 or less	3.8%
• $51 - $100	6.5
• $101 - $150	19.9
• $151 - $200	23.9
• $201 - $250	15.1
• $251 - $300	6.9
• $301 - $350	2.3
• $351 - $400	0.8
• $401 - $450	0.4
• $451 - $500	—
• $501 - $550	—
• $551 - $600	—
• $601 - $650	—
• $651 - $700	—
• $701 - $750	0.2
• $751 - $800	—
• $801 - $850	—
• $851 - $900	—
• $901 - $950	—
• $951 - $1,000	0.2
• Amount varies	0.4
• No response	18.8
• Not applicable	0.8
BASE: Respondents who provide health coverage for their employees' families	(523)

TABLE 5

PERCENTAGE OF PREMIUM PAID BY EMPLOYER

QUESTION: WHAT PERCENTAGE OF THE PREMIUM DO YOU (THE EMPLOYER) PAY?

PERCENTAGE PAID	TOTAL (%)
• None	6.3%
• 1% - 10%	0.3
• 11% - 20%	0.7
• 21% - 30%	1.5
• 31% - 40%	1.0
• 41% - 50%	18.7
• 51% - 60%	0.9
• 61% - 70%	1.4
• 71% - 80%	1.4
• 81% - 90%	0.3
• 91% - 100%	61.9
• Percentage varies	1.7
• No response	3.8
• Not applicable	0.1
BASE: Respondents offering health coverage for employees and/or their families	(1,052)

TABLE 6

DEDUCTIBLE PER EMPLOYEE

QUESTION: WHAT IS THE DEDUCTIBLE PER EMPLOYEE?

DEDUCTIBLE RANGES	TOTAL (%)
• No deductible	13.0%
• $10 or less	0.8
• $11 - $20	0.5
• $21 - $30	0.4
• $31 - $40	0.3
• $41 - $50	1.8
• $51 - $60	0.8
• $61 - $70	0.5
• $71 - $80	0.3
• $81 - $90	0.2
• $91 - $100	21.2
• $101 - $150	3.3
• $151 - $200	19.3
• $201 - $250	9.6
• $251 - $300	2.4
• $301 & over	4.4
• Other*	2.4
• Amount varies	0.4
• No response	17.3
• Don't know/uncertain	0.6
• Not applicable	0.5
BASE: Respondents who provide health coverage for their employees	(1,057)

* These responses did not correctly answer the question as asked.

TABLE 7

DEDUCTIBLE PER FAMILY

QUESTION: WHAT IS THE DEDUCTIBLE PER FAMILY?

DEDUCTIBLE RANGES	TOTAL (%)
No deductible	12.4%
$10 or less	0.2
$11 - $20	0.6
$21 - $30	0.2
$31 - $40	—
$41 - $50	1.0
$51 - $60	—
$61 - $70	0.2
$71 - $80	0.4
$81 - $90	0.2
$91 - $100	7.5
$101 - $150	1.9
$151 - $200	12.4
$201 - $250	6.1
$251 - $300	7.1
$301 & over	17.2
Other*	2.5
Amount varies	0.8
No response	27.6
Not applicable	1.1
Don't know/uncertain	0.6
BASE: Respondents who provide health coverage for their employees' families	(523)

* These responses did not correctly answer the question as asked.

TABLE 8
TOTAL MONTHLY INSURANCE PAYMENTS

QUESTION: WHAT IS THE TOTAL MONTHLY INSURANCE PAYMENT MADE BY THE BUSINESS?

PAYMENT RANGES	TOTAL (%)
• $50 or less	2.5%
• $51 - $100	4.0
• $101 - $150	6.1
• $151 - $200	6.8
• $201 - $250	6.7
• $251 - $300	7.3
• $301 - $350	6.8
• $351 - $400	6.8
• $401 - $450	4.8
• $451 - $500	6.4
• $501 - $550	3.3
• $551 - $600	3.4
• $601 - $650	2.7
• $651 - $700	3.8
• $701 - $750	1.7
• $751 - $800	1.7
• $801 - $850	1.0
• $851 - $900	2.3
• $901 - $950	0.7
• $951 - $1,000	1.4
• $1,001 - $1,250	3.5
• $1,251 - $1,500	1.9
• $1,501 - $1,750	2.0
• $1,751 - $2,000	1.2
• $2,001 & over	3.7
• Other*	0.5
• Amount varies	0.3
• No response	6.6
BASE: Respondents offering health coverage for employees and/or their families	(1,052)

* These responses were given as percentages rather than as a dollar value.

TABLE 9

PRINCIPAL FEATURES OF THE INSURANCE COVERAGE

QUESTION: WHAT ARE THE PRINCIPAL FEATURES OF THE INSURANCE COVERAGE?

FEATURES	TOTAL (%)
• Hospitalization/Surgical and Major Medical	87.4%
• Hospitalization/Surgical Only	3.5
• Major Medical Only	2.6
• Don't Know/Uncertain	3.2
• No Response	3.3
BASE: Respondents offering health coverage for employees and/or their employees' families	(1,052)

TABLE 10

NUMBER OF EMPLOYEES COVERED BY HEALTH INSURANCE

QUESTION: HOW MANY OF YOUR EMPLOYEES ARE COVERED BY THE HEALTH INSURANCE?

NUMBER OF EMPLOYEES	TOTAL (%)
• None	0.5%
• 1	10.5
• 2	16.6
• 3	18.0
• 4	13.2
• 5	9.2
• 6	10.8
• 7	4.4
• 8	3.1
• 9	2.0
• 10	1.9
• 11 - 20	5.8
• 21 - 30	0.7
• 31 - 50	0.5
• 51 & over	0.5
• Other*	0.5
• Number varies	0.3
• No response	1.5
BASE: Respondents who provide health coverage for their employees	(1,057)

* These responses were given as percentages rather than as actual number of employees.

TABLE 11

NUMBER OF PART-TIME EMPLOYEES ON STAFF

QUESTION: HOW MANY ADDITIONAL (PART-TIME) EMPLOYEES DO YOU HAVE WHO WORK AT LEAST 17½ HOURS PER WEEK?

NUMBER OF EMPLOYEES	TOTAL (%)
• None	14.4%
• 1	10.0
• 2	16.2
• 3	13.6
• 4	9.4
• 5	5.7
• 6	4.9
• 7	2.1
• 8	3.4
• 9	1.0
• 10	3.8
• 11 - 20	5.1
• 21 - 30	1.6
• 31 - 50	0.8
• 51 & over	0.7
• Number varies	1.1
• No response	5.9
• Not applicable	0.3
BASE: Respondents who provide health coverage for their employees	(1,057)

TABLE 12

ADDITIONAL BENEFITS PROVIDED

QUESTION: WHAT ADDITIONAL BENEFITS DO YOU PROVIDE FOR YOUR EMPLOYEES?

MAIN RESPONSES	TOTAL (%)*
• Paid vacation**	92.3%
• Life insurance	40.0
• Paid holidays	12.9
• Sick time	7.3
• Merchandise discounts	3.6
• Bonuses	3.4
• Dental	3.2
• Pension plan	2.9
• Compensation/disability	2.9
• Profit sharing	1.7
• Meals	1.0
• Personal time off	0.7
• Workshops/seminars/educational opportunities	0.7
• Accidental death policy	0.6
• IRA	0.6
• Other***	4.1
• None	0.5
• No response	3.6
BASE: Respondents offering health coverage for employees and/or their families	(1,052)

* Due to multiple responses, percentage total exceeds 100.0%.

** Average paid vacation time of 1.6 weeks/year.

*** Other benefits include: legal services, 401K plans, optical, commission, prescriptions, payroll savings plans, free checking, gas/parking allowances, uniforms, professional magazine subscriptions, maternity leave, and social activities.

TABLE 13

IMPACT OF MANDATORY HEALTH COVERAGE ON BUSINESS

QUESTION: IF YOU WERE REQUIRED TO PROVIDE HEALTH COVERAGE TO ALL EMPLOYEES, HOW DO YOU FEEL THIS WOULD IMPACT YOUR BUSINESS?

MAIN RESPONSES	TOTAL (%)*
• Negative/adverse effects/major financial drain/great hardship/can't afford it	28.8%
• Would close shop/go bankrupt/sell out	10.1
• Increase prices substantially	9.7
• Most employees are covered through other sources (ie: spouses/parents)	9.2
• Would layoff/eliminate employees	8.5
• Would build morale/positive impact/cut employee turnover/asset if low rates/in favor of it	8.5
• It's too expensive/costly	8.2
• Little or no impact	7.6
• Salaries would be decreased/adjusted	4.1
• Devastating/disastrous	3.0
• Not necessary/shouldn't be mandatory/not fair	1.9
• Would limit raises	1.9
• Would offer it if employees paid/contributed	1.5
• Hire all/more part-timers	1.3
• Cutbacks on other benefits	1.2
• Government's killing small business/resent Government intrusion/should be florists' choice	1.1
• Not in favor/strongly opposed	0.9
• Enormous impact	0.9
• Could do it if forced/required	0.8
• Too much paperwork/effort/confusion	0.8
• Only family in shop/minimal employees	0.8
• Would limit hiring	0.6
• Cut hours back	0.6
• Would have (general) impact	0.5
• Prefer to offer as an incentive	0.5
• Just cost of coverage	0.4
• Difficult to do because work is seasonal	0.3
• Would allow for competitive hiring	0.3
• Wouldn't do it/not our responsibility	0.2
• Too much employee turnover	0.2
• Some employees are turned down for coverage	0.1
• No response	6.6
• Don't know/depends on cost/need more information	2.9
• Other	0.6
• Not applicable	0.5
BASE: Total respondents	(2,981)

* Due to multiple responses, percentage total exceeds 100.0%

QUESTIONNAIRE

HEALTH INSURANCE COVERAGE SURVEY

FTD CODE #: ____________________ TODAY'S DATE: ______________

1. Do you provide health coverage for your employees?

(CHECK ONE ONLY) a. ( ) Yes b. ( ) No

2. Do you provide health coverage for your employees' dependents?

(CHECK ONE ONLY) a. ( ) Yes b. ( ) No

(IF YOU ANSWERED "NO" TO BOTH QUESTIONS, 1 AND 2 SKIP TO QUESTION 11; OTHERWISE CONTINUE TO QUESTION 3)

3. If you answered "yes" to question 1 and/or 2, what is the average premium per employee and/or family per month? (FILL IN AMOUNTS)

PER EMPLOYEE $_______ PER FAMILY $_________

4. What percentage of the premium do you (the employer) pay?
(FILL IN %) _________%

5. If you answered "yes" to question 1 and/or 2, what is the deductible per employee and/or family? (FILL IN AMOUNT)

PER EMPLOYEE $________ PER FAMILY $________

6. What is the total monthly insurance payment made by the business?
(FILL IN TOTAL AMOUNT) $__________

7. What are the principal features of the insurance coverage?
(CHECK ONE ONLY BELOW)

a. ( ) Hospitalization/Surgical Only
b. ( ) Major Medical Only
c. ( ) Hospitalization/Surgical and Major Medical
d. ( ) Don't know/uncertain

8. How many of your employees are covered by the health insurance?

(FILL IN # OF EMPLOYEES) __________

9. How many additional employees do you have who work at least 17 1/2 hours per week? (FILL IN # OF PART-TIME EMPLOYEES) _________

10. What additional benefits do you provide for your employees?
(CHECK ANY THAT APPLY)

a. ( ) Paid vacation (_____ Weeks)
b. ( ) Life insurance
c. ( ) Other (Specify) ____________________________

11. If you were required to provide health coverage to all employees, how do you feel this would impact your business?

____

SURVEY CONDUCTED

by

Machinery Dealers National Association

MDNA is an international, non-profit trade association, established in 1941, to assure buyers of the integrity and reliability of used metalworking machinery dealers who are members of MDNA. The association represents more than 450 member firms who account for more than 70 percent of the used machine tools sold in the United States. MDNA is comprised of 14 chapters--12 in the United States and one in both Canada and Europe.

MDNA HEALTH INSURANCE COVERAGE SURVEY

>Sent to 398 U.S. members

>83 responded for a 21% response rate

1. Do you provide health coverage for your employees?

NO 5 (6%) YES 78 (94%)

2. Do you provide health coverage for their dependents?

NO 16 (19%) YES 67 (81%)

3. If you answered YES to Number 1, what is the average premium per employee per month? **(63 responses, average premium $109)**

4. If you answered YES to Number 2, what is the average premium per family per month? **(63 responses, average premium $211)**

5. What share of the premium do you (the employer) pay? **(77 responses, 94% average, breaks down as follows: 100% -63, 95% - 1, 90% - 1, 85% - 1, 75% - 4, 65%- 1, 50% - 3, 45%- 1, 41% - 1)**

6. What is the deductible? Per employee? **(64 responses, $195 average, breaks down as follows: $0 - 14, $50 - 1, $100 - 19, $150 - 1, $200 - 8, $250 - 10, $350 - 1, $400 - 1, $500 - 7, $1,000 - 2)**

Per family? **(56 responses, $353 average, breaks down as follows: $0 - 12, $100 - 7, $200 3, $250 - 5, $300 - 10, $400 - 5, $450 - 1, $500 - 5, $750 -3, $1,000 - 2, $1,500-2, $2,000 - 1)**

7. What is the TOTAL monthly insurance premium made by the business? **(73 responses, $1,778 average)**

8. What is the nature of the insurance? **Travelers (2.5), Blue Cross/Blue Shield (38.5), New York Life (3), HMO (2), Group Insurance, Self-Funded, TMA Group Insurance Trust, Aetna (43), Did Not Specify (10), Humana Care Plus, Principal Mutual Life Insurance Co., American Community, Banker's Life (3), PPO, Fireman's Fund (2), Guardian, Combined Employers Trust.**

9. What are the principal features of the coverage?

Hospitalization/Surgical only? 2 (2%)

Major Medical only? 2 (2%)

Hospitalization/Surgical and Major Medical? 73 (95%)

Don't know. 1 (1%)

10. How many employees are covered? (77 responses, average 11.5)

11. How many additional employees work at least 17-1/2 hours per week? (70 responses, average 1, breaks down as follows: 0 - 45, 1 - 10, 2 - 5, 3 - 3, 4 - 2, 5 - 4, 6 - 1)

12. Do you provide other benefits?

Paid vacation: No. of weeks? (66 responses, 2 average, breaks down as follows: 1 - 3, 1.5 - 1, 2 - 49, 2.5 - 7, 3 - 4, 4 - 2)

Life Insurance? YES: 52 (63%)

13. If you were required to provide health coverage to all employees, do you have any observations about the impact on your business?

> It would kill our business.

> We would not hire any part-time or contract employees.

> The few people who we do not cover are single, so it will not hurt badly. I feel it should be voluntary. The government has no right to meddle and make demands that are none of their business.

> We have just hired two more people which is going to double our insurance costs even if they pay half. With the liability and vehicle insurance increasing also, we are seriously considering closing up in the near future even though we are so busy and have to expand. Today expansion means heavy uncontrollable costs, very little profit! It is almost impossible to keep help because of what is "mandatory". Small business is suffering.

> We are a rather small organization. I already have a tremendous overhead as it is. If I was forced to pay $300 per employee per month, I hate to think of the impact such a large expense. I would imagine a lot of people may be forced to close their doors.

> I think it's part of the cost of doing business and I prefer my people are taken care of this way, then by some government system.

> Another burden that could cause consideration of change in operation where there would be no steady or full-time employees.

> Such coverage would not be helpful to us and would be disproportionately expensive.

> $200-$300 per month per employee is way too high. We wwould certainly be less likely to increase employment and would prefer to hire a single person instead of a married person with a family as we pay 100 percent of medical for our people.

> If it were required by law, you can damn sure bet the premiums would be higher than they are now!

> We would be forced to consider providing/offering a less costly (and most likely, less beneficial) type of coverage. Also, we would probably consider this benefit during compensation reviews and adjust employees' increases as necessary.

> Not very much since we pay most of it now. However, if costs went up substantially, and if we couldn't go to the employees for a higher percentage, it could be a bitter pill.

> Negligible.

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Associated Landscape Contractors of America
Association of Physical Fitness Centers
Association of Small Business Development Centers
Association of the Wall and Ceiling Industries-International
Automotive Service Association
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Christian Booksellers Association
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Electronic Representatives Association
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International Bottled Water Association
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International Fence Industry Association
International Franchise Association

-more-

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National Association for the Self-Employed
National Association of Aircraft and Communication Suppliers
National Association of Brick Distributors
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National Association of Development Companies
National Association of Home Builders
National Association of Investment Companies
National Association of Manufacturing Opticians
National Association of Personnel Consultants
National Association of Plumbing-Heating-Cooling Contractors
National Association of Realtors
National Association of Retail Druggists
National Association of Small Business Investment Companies
National Association of the Remodeling Industry
National Association of Truck Stop Operators
National Association of Women Business Owners
National Candy Wholesalers Association
National Chimney Sweep Guild
National Coffee Service Association
National Council for Industrial Innovation
National Electrical Contractors Association
National Fastener Distributors Association
National Grocers Association
National Independent Dairy-Foods Association
National Motorcycle Retailers Association
National Moving and Storage Association
National Office Products Association
National Parking Association
National Precast Concrete Association
National Shoe Retailers Association
National Society of Public Accountants
National Tire Dealers & Retreaders Association
National Tooling and Machining Association
National Tour Association
National Venture Capital Association
Opticians Association of America
Petroleum Marketers Association
Printing Industries of America, Inc.
Retail Floorcovering Institute
Small Business Council of America, Inc.
Smaller Manufacturers Council
Society of American Florists
Specialty Advertising Association International
United Bus Owners of America
Web Sling Association

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**National Federation of
Independent Business**

NFIB

STATEMENT OF

NFIB

Submitted to:	Senate Labor and Human Resources Committee
Subject:	S. 1265, "Minimum Health Benefits for All Workers Act of 1987," and Alternative Strategies for Extending Health Insurance Coverage to Employees of Small Firms
Date:	November 4, 1987

Mr. Chairman, NFIB is a voluntary membership organization with over 500,000 small business owner members. Our membership comes from all of the industrial and commercial categories and reflects the national small business community in its distribution among industries. That is, we have about the same percentage of members in the construction industry, the manufacturing industry, wholesale, retail, etc., as exists in the national business profile.

While we seize this opportunity to submit testimony to the committee on your proposal, S. 1265, requiring all employers to provide health insurance coverage for their employees, we are deeply distressed at your refusal to hear testimony on behalf of the nation's small employers. Small business has taken over the role as the leading engine of America's job creation over the past decade, and the debate over mandated benefits strikes at the very heart of this economic miracle.

At the 1986 White House Conference on Small Business, over 1800 delegates representing the entire United States voted, as their number two recommendation to Congress and the President, opposition to all types of mandated benefits. This recommendation was superceded only by a call to end the liability insurance crisis. Further, a 1986 survey of NFIB members, entitled Problems and Priorities, revealed the number one problem facing small business today is the cost of health insurance.

Clearly for NFIB members and their more than 7 million employees, much is a stake in the current debate over mandating health benefits. For the record, our recent polling on this issue (April 1987) found an overwhelming eighty-nine percent of our membership opposed to this type of federal policy (7 percent were supportive and 4 percent undecided). Eighty-nine percent of the membership also oppose a state mandate to provide catastrophic coverage as a part of their health insurance plans.

While NFIB is a recognized authority on small business, we are not experts in the health care industry or in the insurance industry, therefore our remarks are primarily directed to a description of the attitudes and operational characteristics of the small business community that are relevant here. First, we will summarize some of the results of our survey material, then we will briefly discuss their policy implications from a small business point of view and make some recommendations for alternative strategies.

The primary basis for our remarks come from two national surveys we have conducted in this general area. The first was done in 1978 and is entitled National Health Insurance Report on Small Business. The second, conducted in late 1985, is entitled Small Business Employee Benefits.

Coverage Among Small Firms

Small firms are not unlike their larger counterparts in recognizing the value of employer-provided health benefits. The number of small business owners providing employee health insurance has been rising as the ability to pay for these benefits increases.

According to our national survey in 1985, sixty-five percent of firms offer health insurance for at least some full-time employees, an increase of eight percentage points from a similar finding in 1978. Forty-two percent of small firms provided health insurance to all full-time employees. Subsequent field survey data from April of this year indicate as many as seventy-five percent of those who provide fringe benefits are providing health insurance. This, despite the fact that in 1985, the median monthly health insurance premium paid by small employers was over $1,766, more than double the monthly premium paid in 1978. The rising cost of health insurance is the number one problem as reported in NFIB's 1986 Small Business Problems and Priorities study.

The vast majority of firms in all size categories offer plans that include hospitalization/surgical and major medical. In the aggregate, nearly two-thirds of these employers pay the entire premium cost, with smaller firms more likely to pay 100% of the premium than larger firms. Well over eighty percent of health insurance plans offered in small firms carried an option for dependent coverage.

Employee health insurance was not provided by about one-third of small employers. No single reason dominated their decisions. The most frequently cited reasons were: employees covered under a spouse or parent policy (secondary wage earners); premiums were too high; employee turnover was too great; the firm's profitability was insufficient; or the firm couldn't qualify for a group policy. There is a fringe benefit hierarchy for small employers. Paid vacations are provided first, with health insurance becoming available as the firm matures and begins to make a profit.

In their May 6 testimony, the Health Insurance Association of America outlined three primary reasons for higher premiums for small employers:

1) higher acquisition (marketing and underwriting) and fixed administrative expenses which must be recovered from a smaller number of employees;

2) the behavior of small business in the marketplace, i.e. lower renewal rates and adverse selection; and

3) government regulations, particularly state-mandated benefit laws.

NFIB evidence would support much of their reasoning -- evidence accumulated through our benefit surveys and first-hand experience in launching our own group medical insurance program, the details of which we will share with you later in our testimony.

Review of these facts and the extensive results of our employee benefit surveys lead NFIB to believe that small employer-sponsored health care plans can best be expanded by:

1) reducing health insurance costs by reducing or eliminating state and federal mandates;

2) expand the health insurance premium income tax deduction for unincorporated businesses;

3) offering more realistic tax incentives to small firms; and

4) encouraging the further development of group plans and multi-employer trusts (METs).

State Mandates

NFIB does not believe mandating benefits at the federal or state level is prudent public policy. State mandates for specific types of benefit coverage now number more than 600.

They have seldom surfaced as a result of constituent demand, but rather have been initiated by well-organized special interest groups, including the providers of services themselves.

The end result of benefit mandates in many states has been a remarkable growth in the number of providers performing the mandated service -- providers who suddenly find that payment for all services is available, indeed mandated, by state law. In Wisconsin, the passage of a mental health mandate resulted in a phenomenal rate of growth in the number of outpatient mental health clinics -- from less than 40 to more than 900 in ten years.

In Maryland, state-mandated insurance benefits were estimated to raise the combined average cost of group and individual Blue Cross & Blue Shield coverage by more than 11% in 1984; outpatient mental health benefits alone were estimated to raise total plan costs by more than 4%. Mandates eliminate the cost control provided by comparative choice and increase the cost of health services.

Benefit mandates take coverage out of reach due to the legislative dictates of benefit design. They take away the right of the insurance purchaser to select and pay for coverages based on need and ability to pay. Instead, buyers end up spending scarce resources on benefits that they may not want or use, or reducing coverage for more essential health services in order to accommodate the extra costs associated with mandates.

Larger employers with self-insured plans already avoid state-mandated benefits and taxation under protection from the 1974 Employee Retirement Income Security Act (ERISA), which exempts employee benefit plans from state regulation.

One viable option for reducing the cost of health insurance to small employers would be to protect their plans from government actions that arbitrarily increase the cost of health plans.

Tax Incentives

Tax incentives for health insurance have encouraged the spread of private coverage, protecting people from financial hardship and the public from carrying their burden. The United States will forgive about $35 billion in taxes owed in 1987 to provide this protection to about 146 million people.

The federal tax code has, since 1954, provided a double subsidy for health insurance bought for employees by employers. The employer's taxable income is reduced by the amount of health insurance premiums paid, and the employee doesn't have to include the dollar value of the insurance in his or her income. Despite this strong commitment to encourage businesses to provide health insurance through tax incentives, small unincorporated business owners have never been afforded the same privilege as their corporate counterparts.

The Tax Reform Act of 1986 made some movement in rectifying this unequal treatment by allowing a 25 percent tax deduction for health insurance premiums paid by unincorporated business owners.

Forty-two percent of these business owners have no health coverage. Sixteen percent of all uninsured workers in 1985 were self-employed. Health benefits can and should be expanded to these owners and their families by extending them an equal 100% health premium tax deduction.

Income tax deductions to purchase health insurance are an ineffective incentive for new and marginal firms. If you're not making money, there's nothing to take a deduction against.

A more viable tax incentive would be a deduction against payroll taxes. From the first dollar they pay in salary --

even to themselves -- small business owners pay payroll taxes, and to be of any real value, the incentive must be against a tax they pay.

For our members, payroll taxes aren't just another cost of doing business. Payroll taxes, for a majority of small firms, constitute more of a burden than any other form of taxation. Today, nearly one of every three federal tax dollars collected is a payroll tax, and this burden remains a constant threat to small, labor-intensive firms. NFIB recommends that the committee explore payroll tax credits as a viable incentive for expanding small employer health care coverage. We believe this kind of encouragement could go a long way in providing coverage for many marginal employers and their workers.

Group Plans

Our surveys show that small business owners purchase private health insurance from a great variety of carriers. While the firm was the group sponsor more often than not, trade/business associations have been increasingly taking that role, including NFIB.

During 1984, NFIB developed a comprehensive group medical program for our over-500,000 small and independent business owners, many of whom had requested that we offer such a program because of the lack of group insurance for businesses in the 1-10 employee category. Corroon & Black Benefits, Inc., located in Nashville, Tennessee, was contracted with and began the laborious task of finding an insurance carrier to handle a program of the proposed size. The carrier chosen was State Mutual Life Assurance Company of America in Worcester, Massachusetts.

One of the criteria specified by NFIB for this fully-insured program was to use our NFIB member insurance agents to sell the program, thus not competing with our members' businesses. The member agents in each proposed state are notified in advance of the direct mailing to our members in the state and given the opportunity to participate under contractual agreement in selling the program to their fellow members.

The program was initially test-marketed in 7 southeastern states, and an additional 3 states were added to the program in 1986. These ten states represented one-third of our national membership. In 1987, 7 more states will be added during the course of the year, and the program should be available to all members of NFIB by 1989.

NFIB members are contacted about the program through a direct mail campaign and by personal contact of our membership representatives during their calls. Each member receives a brochure describing briefly the coverages being offered, and a business reply card through which they can request additional information from the insurance administrator. These lead generation pieces are returned to Corroon & Black, which then assigns each member lead to a participating agent in the member's geographic area. The agent then calls on the member to present the plans available which fit that firm's need. Information concerning rates and premiums are calculated by the agent for the member, as rate schedules for the program are on a geographic basis.

With the exception of the dental option (for 3+ employees), all plans are available to the members regardless of size of firm, providing they meet the carrier's restrictions and underwriting requirements.

During the last half of 1986, and the last three months in particular, the program grew at an accelerating rate. From January through December, the program more than quadrupled in size.

In terms of business size, measured by number of employees, the percentage of leads from members of different sizes closely paralleled the composition of the national membership. Sales, on the other hand, are clustered among smaller firms. While 1-2 employee firms constitute about one-quarter of the membership and about one-quarter of the leads, these firms were responsible for a much larger percentage of sales: 44.9%. This pattern has remained basically unchanged since early in 1986 and shows that the program continues to meet the needs of our smallest members.

Program improvements have included changes in underwriting restrictions so that now firms need only have been in business for 13 months to be eligible to apply. Previously, a firm had to be in business for a minimum of 24 months to be eligible to apply for coverage. This type of underwriting restriction is due to the extreme volatility of small firms.

A long-term disability program is to be added to the program. Alternative health care delivery systems, a Preferred Provider Organization (PPO) will be test-marketed by the end of the year, and a prescription drug savings program will be evaluated for possible implementation.

Other new, no-cost benefits have been added. One is an innovative seat belt benefit: if an insured is injured while driving and is wearing a seat belt, the deductible on the health insurance plan is waived. Insurers who discover errors on their hospital bills can earn cash bonuses of up to $1,000 under a new hospital audit bonus. This is an important cost containment measure considering reports from bill-auditing firms that ninety-seven percent of the bills audited in 1984 and early 1985 contained errors resulting in overcharges averaging four percent of the audited bill!

Also, each enrolled firm's employees now receives a Wellcare Newsletter containing timely articles on diet, exercise, stress, and tips for a healthier, longer life. Public health officials estimate that one-half the costs of illness are from conditions that might be prevented by staying fit, eating wisely, not smoking, and drinking alcohol in moderation.

We believe the trend to greater association sponsorship is tied directly to increasing employee health coverage in small firms. An effective way to reduce the health insurance coverage gap would be to find ways to encourage the setting up and expansion of these types of plans.

Unemployed and Marginal Workers

The majority of uninsured who do not have access to employer coverage are considered too poor to comfortably purchase individual policies and too rich to qualify for government health programs. Seventy-five percent of the working uninsured earn less than $10,000 a year. They work in what we call marginal, or expendable, jobs.

For unemployed and marginal workers, employer-sponsored care is an obvious unlikelihood. Yet, the predominant federal program for assisting the poor -- Medicaid -- serves less than forty percent of the poor. The program initially covered about sixty percent, but coverage has eroded largely because states have set income eligibility levels well below federal poverty levels and categorical restrictions limit eligibility and coverage for certain families.

Perhaps we should study ways to encourage states to develop "Medicaid buy-in" programs for unemployed and marginal workers. These aspects of the problem may be more amenable to correction through the public policy process.

Proposals for Federal Mandates

By any measure, the U.S. continues to endure a health care cost crisis. Since 1965, medical costs have doubled as a share of Gross National Product from under six percent to over eleven percent. Last year the U.S. spent $460 billion on health care, a greater proportion of GNP than any other nation in the world and more than the total GNP of all but a handful of countries! Recent reports see a tripling of health care costs, with a fifteen percent share of GNP by the year 2000. Mr. Chairman, that's the scandal. The employer community is the victim.

Employer expenditures for health care and health insurance continue to rise at more than twice the rate of inflation. Spending was nearly five percent more than that of the preceding year in inflation-adjusted dollars.

In 1985, the average small firm spent approximately $1,750/month for employee health insurance coverage -- more than twice the sum spent in 1978. Is it any wonder that small employers have extreme difficulties buying into the world's most expensive health care system?

Through current mandate proposals, Congress is attempting to close the health care gap without paying anything. The result could be just as expensive as direct expenditures, possibly more so.

Rather than require direct public expenditures, any strategy to mandate benefits taxes a job and is likely to hit hardest at those who most need employment and for whom higher wages are likely to be preferable. Congress would be attempting to shift what one could argue is a legitimate social burden to those least able to provide.

Mandating benefits is a mandatory increase in real compensation. It will affect job availability, particularly for low-skilled workers. The most recent research on the effect of minimum wage laws suggests that the minimum wage has the effect of eliminating the lowest-skilled workers from the market and potentially altering the entire wage distribution among workers who remain employed.

If they are to remain competitive, small firms cannot be expected to pay for mandated benefits by shifting costs to consumers by raising prices. They might be able to reduce wages, but for lower and minimum wage employees whose compensation cannot be reduced, there is a greater likelihood for increased layoffs or reduced hiring. These consequences should not be overlooked.

The risk-taking nature of small business owners is such that they're willing to take a chance. In many instances, they're the employer of last resort -- marginal employers picking up marginal employees, all of which has had some very positive results and feeds our economic system.

Recognize that, indeed, many small employers themselves would be considered marginal at best. The 1983 median annual earnings for full-time business owners, men and women respectively, were $15,600 and $4,984. This compares to male and female employees, $20,039 and $12,079 respectively (according to the Monthly Labor Review, May 1987, U.S. Department of Labor, Bureau of Labor Statistics).

There are now more than 15 million small businesses in the United States, many of whom employ the young and old, women and minorities in larger proportions than our competitors in big business. Two-thirds of all American workers get their start in a small firm.

In 1985, the number of jobs nationally increased by 2.7%. The number of jobs in small business-dominated industries rose by 5.1%. These include construction, retail trade, and services (incidentally, those most lacking in health care coverage). During the same period, employment in large business-dominated industries rose by only seven-tenths of one percent (0.7%). Minority self-employment rose to an all-time high of 522,000, contrasted with 337,000 ten years earlier.

While we are making suggestions as to how coverage through small firms might be expanded, we must recognize that much of the problem is structural by nature. Federal mandates will only exacerbate the problem.

The economics of mandated benefits are pure and simple. If you legislate the cost of labor upward -- particularly, marginal labor for marginal firms -- less labor will be demanded and those jobs will start evaporating.

"Europeanization"

The European experience with mandated benefits is that it has increased the fixed costs of hiring to the point of stagnation. Much of our competitiveness threat is now coming from Japan and Asia. The compensation in these countries is such that government mandating of even a minimal level of benefits for U.S. employees will almost certainly reduce our competitiveness and is likely to result in the loss of U.S. jobs.

NFIB has coined a term for this very real danger -- "Europeanization." We fear the effects from following in the footsteps of our European neighbors who have chosen to mandate a large proportion of their total compensation package. The results: few new business starts, no job growth, a sluggish GNP, high structural unemployment, and long periods of joblessness for displaced workers. The charts in our appendices, prepared by the NFIB Foundation, illustrate several of these factors.

The big boys in business are crying "no free lunch," and suggest mandates are the answer. Their friends in Congress say, "It's time to put those (health care) costs where they belong -- on the shoulders of the minority businesses that refuse to protect their worker's health."

Joseph Califano, the former Secretary of Health, Education, and Welfare and now in charge of containing health care costs for Chrysler Corporation, testified that a minimum health care bill would improve American competitiveness by taking the Nation's charity burden off the balance sheets of our internationally competitive businesses.

First, Mr. Califano, or anyone using this argument, needs to put his facts where his mouth is and prove them. Second, someone who lives in a glass house shouldn't go around casting stones.

Apparently, Mr. Califano has forgotten that the last time Chrysler couldn't meet its payroll, it received one of the largest government bailouts in history. Not so for small firms who have to find ways to meet their payroll everyday or go out of business.

Since the start of the decade, almost 13 million new jobs have been added to the American economy -- small business has been responsible for the lion's share. According to David Birch of MIT, over seventy percent of all net new jobs have been created in firms with fewer than 100 employees, and seventy percent of that number occurred in firms with fewer than 20 employees. Let's not kill the goose that laid the golden egg. America continues to need jobs; without jobs, there are never benefits.

Conclusion

There are ways to encourage the expansion of health insurance coverage to employees of small firms. Put small business on a footing more equal to their larger competitors -- equalize the health insurance premium deduction, provide equal protection from state benefit mandates, and explore offering more workable incentives to small firms.

But we must tell you, much of the problem is structural. First, profitability is insufficient, while insurance costs continue to escalate.

Second, we have just been through a period of record numbers of new business start-ups. Add those that leave -- both tend to be marginal -- and a certain number of employers, about 20 percent, are not financially able to provide significant fringe benefit packages.

Health insurers do not want to cover these new firms. Carriers generally require a two-year waiting period for new businesses and other underwriting restrictions because of size and risk. Even NFIB's group policy requirements have to recognize the marginal status of new firms. Our group plan requires a 13-month waiting period (previously, 24 months). The data we have indicate small employers provide health insurance benefits when they are able. Also, sixteen percent of the uninsured are self-employed.

We would reiterate that small employers continue to offer health insurance as it becomes more affordable. They are the true victims of a health care cost crisis. Health care expenditures have increased over 800 percent since 1960, while the Consumer Price Index (CPI) increased 110.6 percent during the same period. That's the problem -- not the small entrepreneur who is risking everything in the marketplace, providing jobs that wouldn't exist otherwise.

Attachments

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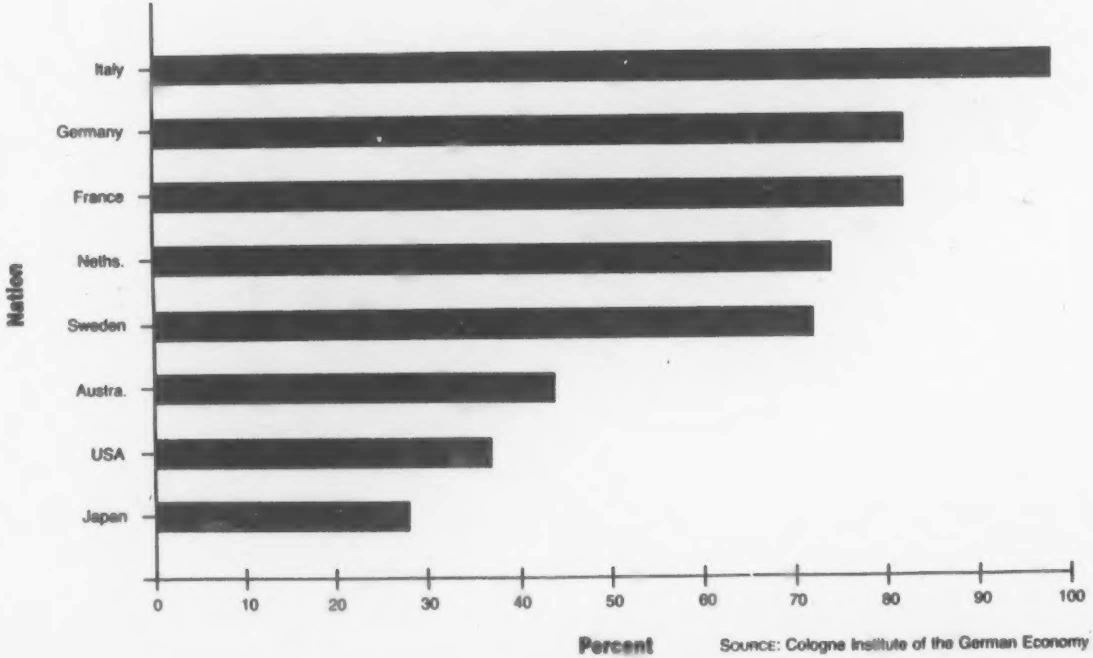
Chart 1

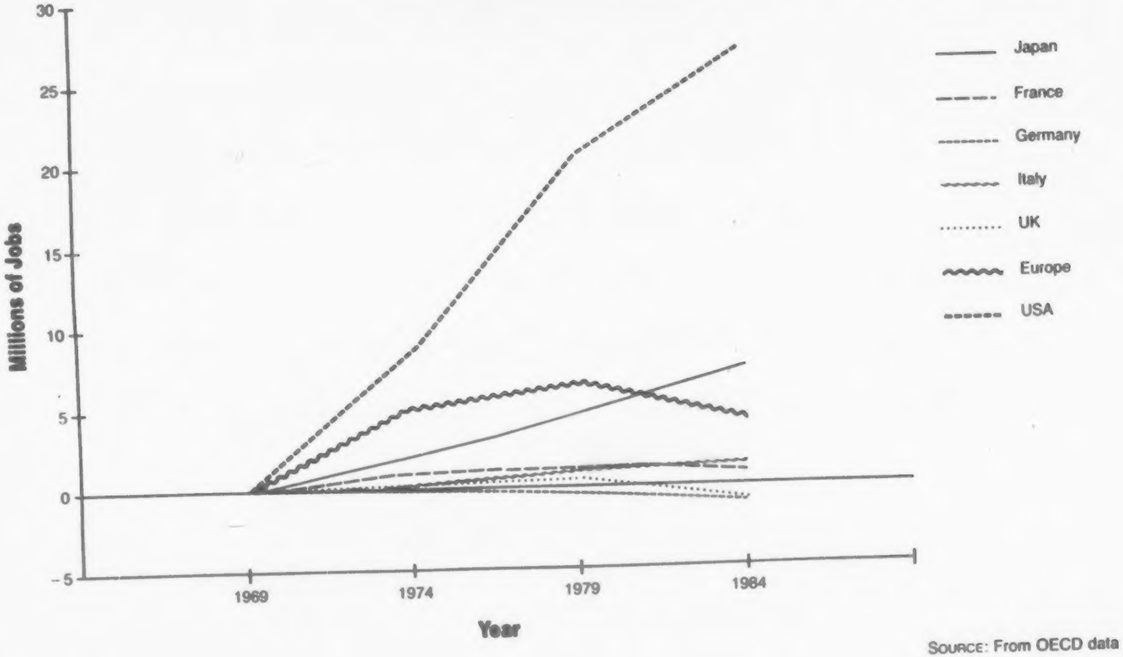
Fringe Benefits as a Percentage Of Wages in Manufacturing Industries By Selected Nation: 1985



SOURCE: Cologne Institute of the German Economy

Those nations with the highest proportion of benefits to wages -- Italy, Germany, France and Europe as a whole -- also have the lowest levels of employment growth

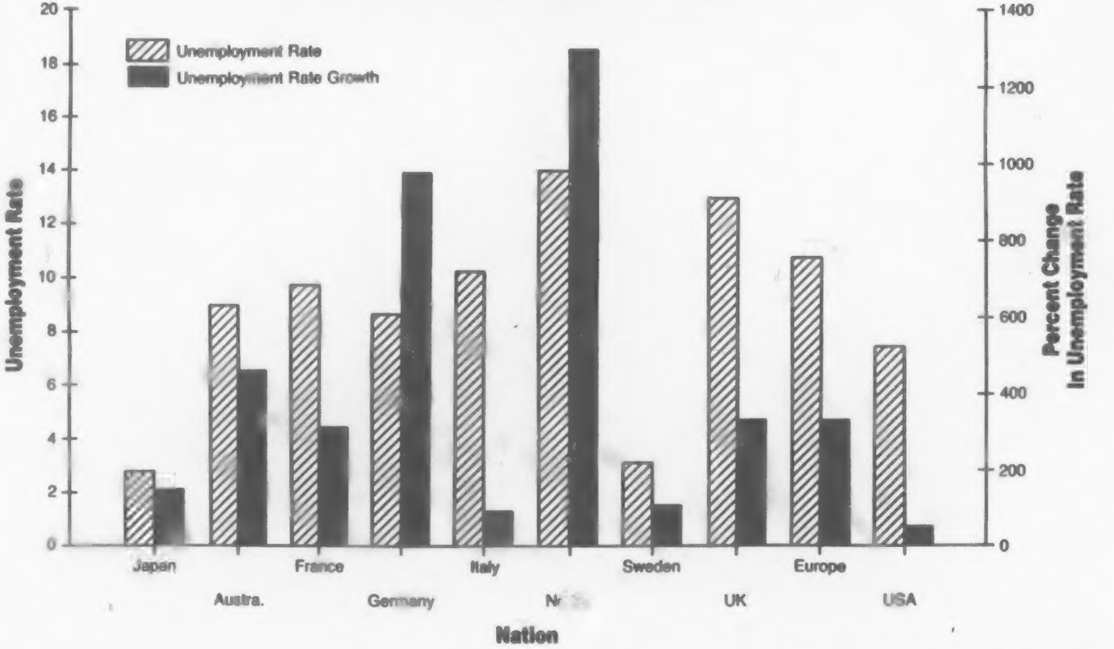
Cumulative Growth in Total Employment For Selected Nations At Five Year Intervals



Source: From OECD data

Chart 3

Unemployment Rate (1984) and Percent Growth In Unemployment Rate (1970–1984) by Selected Nation

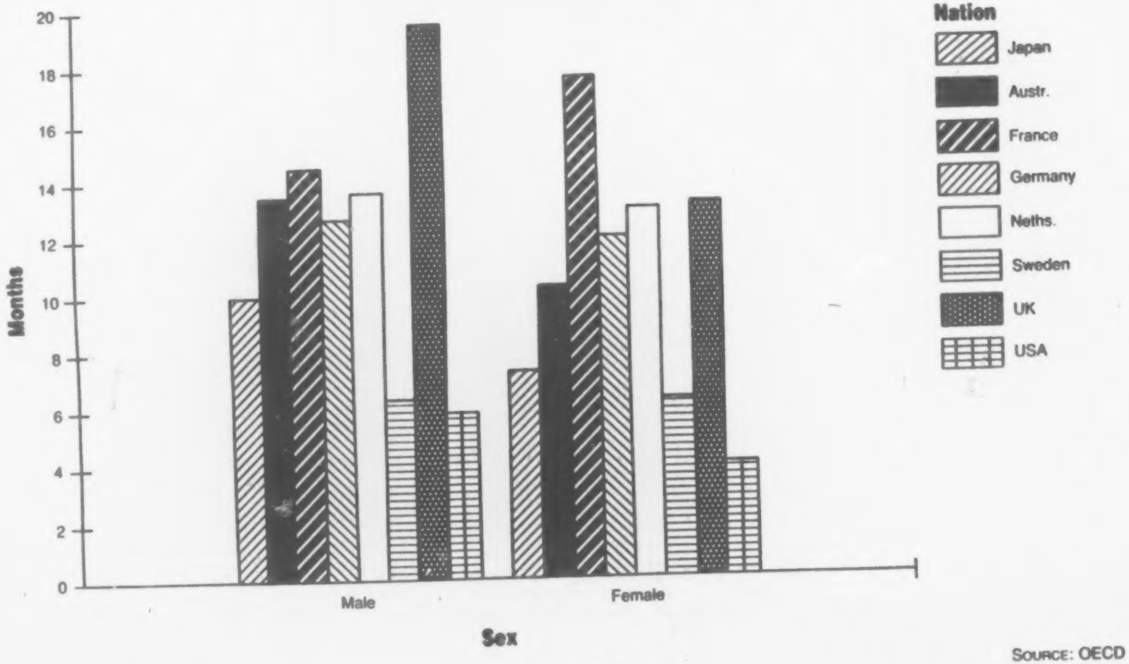


SOURCE: OECD

These same nations exhibit higher levels of unemployment and longer durations of unemployment (Charts 3 & 4).

Chart 4

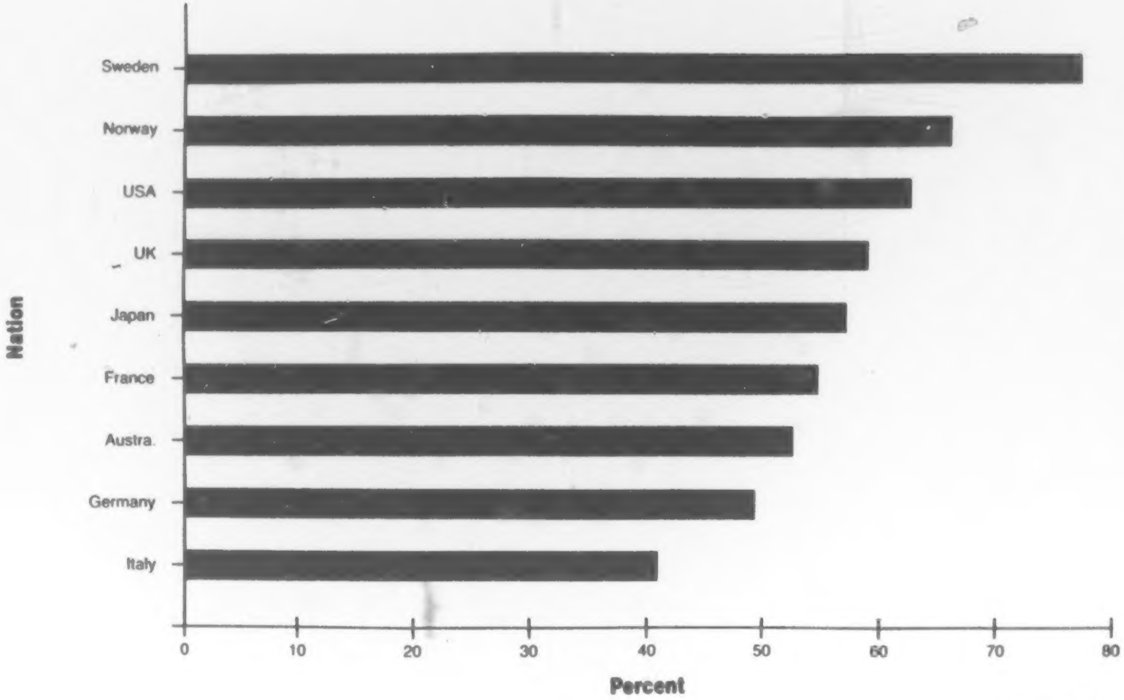
**Mean Average Duration
Of Unemployment in Progress
By Selected Nation—1984**



SOURCE: OECD

Chart 5

Female Labor Participation Rates By Selected Nation—1984

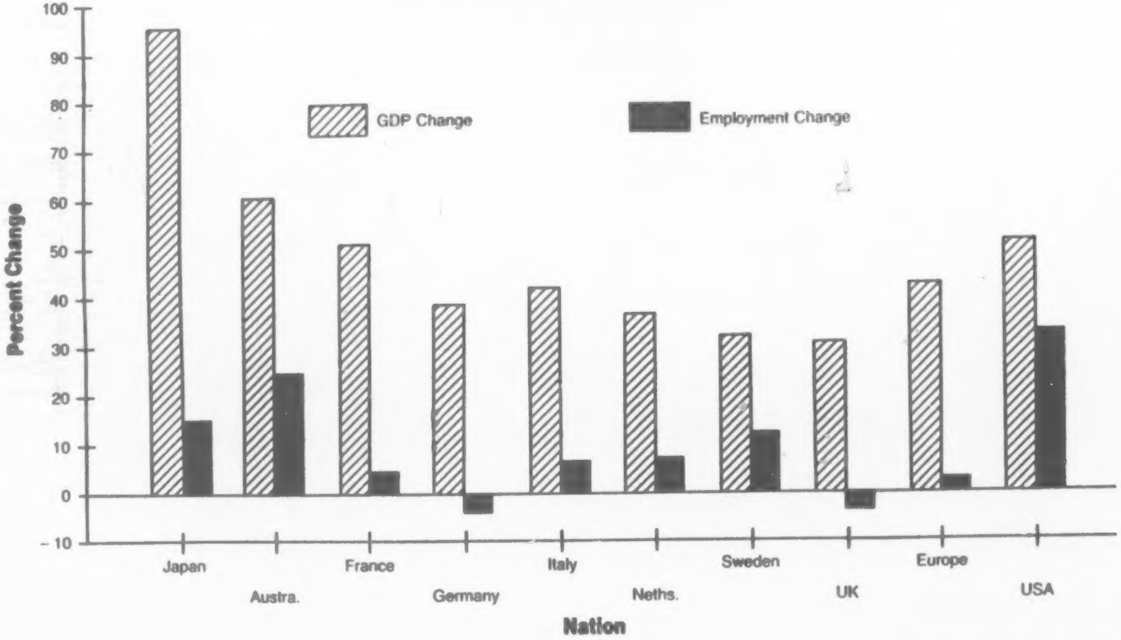


Source: OECD

Morever, in looking at female labor participation rates, it would appear that increasing fringe benefits (as a percentage of wages) has no effect (Chart 5).

Chart 6

Growth in GDP (1970–1985) and Employment (1969–1984) By Selected Nations



Source: From OECD data

American companies have been boosting their productivity by adding more capital and more labor, but European companies have been utilizing capital instead of labor. Labor market rigidities, wage and benefit mandates are resulting in excessive substitutions of capital for labor in Europe (Chart 6).

TESTIMONY OF BELLSOUTH CORPORATION
BEFORE THE
SENATE LABOR AND HUMAN RESOURCES COMMITTEE

S. 1265

The "Minimum Health Benefits for All Workers Act of 1987"

November 4, 1987

BellSouth Corporation appreciates the opportunity to express its views on S. 1265, The Minimum Health Benefits for All Workers Act of 1987.

BellSouth is headquartered in Atlanta, Georgia and includes among its subsidiaries Southern Bell, South Central Bell, BellSouth Services and numerous unregulated subsidiaries involved in lines of business such as directory publishing, equipment sales, cellular communications, and international ventures. Most of our business is conducted in the states of Georgia, Florida, Alabama, Mississippi, Tennessee, Kentucky, South Carolina, North Carolina and Louisiana where we provide local access telephone service; however, we are also involved in various business activities throughout the United States and several foreign countries. BellSouth and its affiliates employ over 96,000 people and almost 40,000 retirees participate in some or all of our employee benefit plans. Therefore, our Company's financial success and employment opportunities are vital to the economy of those areas in which we do business.

A variety of employee benefits are provided to employees of BellSouth Companies, although not all of our companies participate in all plans. Among our benefit plans that are provided to a majority of our employees are two qualified defined benefit pension plans, two Section 401(k) thrift plans, a paysop employee stock ownership plan, a self-funded medical benefit plan for active employees and retirees, self-funded disability plans, a self-funded vision care plan, self-funded dental care plans for active employees and retirees.

The medical plan is being modified effective January 1, 1988 to incorporate cost control features that include utilization management and preferred contractual arrangements. The annual cost per active employee, loaded for all pay-as-you-go retiree funding, is about $3,000. The cost of this coverage is increasing at an unacceptable rate. Therefore, we are acting through plan design, plan financing, employee education, and buying power to lower the rate of increase.

Although BellSouth does not oppose health care protection being made available to all Americans, it does oppose the government mandating uniform employer provided benefits for all companies regardless of the nature of the business and its work force, the size of the company, the company's financial situation and other factors unique to specific types of businesses. No single program can meet the needs of all employee groups and no program should be implemented without assessing its full impact on the economy of the country, medical inflation, unemployment, and competitiveness in the international marketplace.

Mandating benefits will increase medical costs which will further increase medical inflation that is already a national crisis. All of the extra benefit costs stimulated by mandated benefits will affect competitive pricing of American goods and services and will contribute to increased inflation.

S. 1265 contains certain specific restrictions on pre-existing coverage exclusions, mandated coverage for well baby care, and prenatal care without any co-payments or deductibles. Even BellSouth's comprehensive plans do not contain such costly provisions. In fact, their inclusion would be counter to the benefits philosophy we have adopted which calls for co-payment at time of service delivery unless cost containment services are being used. BellSouth believes that benefit design should be an issue resolved by each employer and its employees. Specific benefits mandated by such legislation could easily lead to more and more of this type of coverage on a piece-meal basis without consideration being given to the overall plan provisions. BellSouth is in favor of the government providing tax incentives to encourage employers to make health benefits available to their employees, thus providing the advantage of group rates and lower administrative costs for the individual. However, coverage should not be mandated.

S. 1265 requires that the employer pay the majority of the cost premiums (80%) or, in some cases, pay the total cost may not allocate the compensation package according to the needs of the employee group. Prorating the cost for employees who work less than "full time" is more realistic and encourages the use of part-time employees. The providing of coverage for employees who normally work as little as 17 hours per week, which is mandated in this legislation, is unrealistic and increases unit labor cost substantially. The Bill's approach will provide a disincentive to hiring part-time employees and preclude many qualified Americans from entering the labor market.

When an employer provides medical coverage each employee's plan should be primary for that individual. This would avoid shifting health care costs from companies that do not have health care to companies that do provide quality health benefits. However, the eligibility requirements contained in the legislation would substantially increase administrative requirements and expense. Requiring a mere 30 day waiting period for eligibility creates an undue administrative burden for employers with high turnover in the first weeks of employment where turnover is the greatest. Also, the medical plan extension that is mandated by COBRA will compound the difficulties of providing coverage. Even if a form of this legislation were passed, employers must have the flexibility to permit at least a six month waiting period, and provide for pre-existing medical condition exclusions.

We are pleased that the legislation recognizes other plans, on an actuarial equivalent basis, that can be provided and meet the minimum health coverage plan. While the provision gives employers more flexibility in plan design, it may be more difficult to prove that the equivalent criteria were met than actually meeting the test. Therefore, the actuarial standards should be kept simple, i.e., based on benefit plan cost.

BellSouth does not oppose the preferred provider option and incentives to encourage wise use of medical care that are contained in the Bill. These measures are important in controlling health care costs and are common in most employer plans. Also, we do not oppose the concept of providing access to coverage for small businesses through a regional program by aggregating into a large insurance unit to obtain group rates and lower administrative costs. By placing the coverage through a competitive bid process with insurance carriers some of the administrative costs may be reduced. However, the cost savings may not be as great as thought since some small units will be able to adverse select against the regional operation. Therefore, the costs may still be high when compared to a larger more normative group.

Providing health care protection for employees can be addressed through means other than legislative mandate. Protection should be encouraged through tax incentives and the Medicaid program could be expanded to allow smaller employer groups to participate in the program. Their participation could be controlled through means tested premiums and as the companies expand in size and profitability they could establish their own plans. A large number of employers have provided and would continue to provide health care if they were given the means and flexibility to do so. However, this proposed legislation would make recordkeeping, discrimination testing, and documentation more difficult, is counter-productive and could lead to less coverage.

Employers do not have the ability to fund all social programs believed desirable by the Congress. The cost of these mandated programs would eventually result in higher consumer prices which in the case of BellSouth would result in higher prices for its ratepayers and other consumers. Our current balance of trade indicates that we are experiencing difficulty being competitive in the international market. Increasing the cost of doing business will only compound the problem and ultimately lead to the loss of jobs. On the other hand, a higher employment rate would lead to more competition for employees which in turn would encourage greater compensation--including expanded medical coverage. BellSouth opposes S.1265 because it does not take into consideration the individual circumstances of individual businesses, industries, and employees and could easily have an adverse impact on the economy of this country.

We appreciate the opportunity to provide our views on this important matter and we will be glad to work with this Committee to try to find solutions to these difficult issues.

ABC
ASSOCIATED BUILDERS
AND CONTRACTORS, INC.

STATEMENT OF
ASSOCIATED BUILDERS AND CONTRACTOR
FOR THE RECORD OF THE
SENATE LABOR AND HUMAN RESOURCES COMMITTEE
REGARDING S.1265
THE MINIMUM HEALTH CARE FOR ALL WORKERS ACT

November 4, 1987

729 15th Street, NW • Washington, DC 20005 • (202) 637-8800

The Associated Builders and Contractors (ABC) appreciates this opportunity to comment on S.1265, The Minimum Benefits for All Workers Act.

ABC is a national construction industry trade association representing 20,000 general contractors, subcontractors, and related industry firms. ABC members adhere to the Merit Shop construction philosophy which holds that construction contracts should be awarded to the lowest qualified bidder regardless of labor affiliation.

ABC shares the concerns expressed by the proponents of S.1265 about the growing numbers of Americans, estimated today to range from 32-37 million, with no health insurance coverage. We also recognize that federal and state lawmakers are under extreme pressure to find solutions to the problem and understand that large federal deficits prevent new or expanded public program responses.

Nevertheless, ABC believes that shifting the burden of worker health coverage to employers through broad-stroke mandate is not an effective alternative.

The recent revolution in health care toward employment-based and employer provided health insurance has resulted in private sector-sponsored coverage for 75-80 percent of all workers. In fact, 97 percent of full-time workers in medium and large companies participate in employer-provided health plans.

We believe that taking a close look at the 37 million without insurance speaks to why a mandate like that proposed by S.1265 is no solution to this serious problem.

According to a recent analysis of 1984 Census data by the U.S. Small Business Administration, more than half the uninsured are non-workers, primarily children, and an additional 10 percent have been employed but are currently out of work. The remaining 35 percent of uninsured currently are employed, most either as sole proprietors of their own business or as workers for firms with less than 500 employees. More than 48 percent of all uninsured workers are employed by firms with less than 24 employees, the "smallest of the small" businesses.

The employment-based minimum health insurance requirement proposed in S.1265 would be relatively ineffective in attacking the problem faced by non-workers. Ironically, non-workers face the greatest burden from rising medical costs.

As to the effectiveness of a mandate in helping that 10 percent of the uninsured recently employed but now out of work, the health coverage continuation provisions enacted in the Consolidated Omnibus Budget Reconciliation Act (COBRA) in 1986 should increase the number of laid-off workers who retain health insurance. With the ink barely dry on COBRA, ABC urges the committee to objectively analyze its impact on the uninsured before enacting a costly new mandate.

Realistically, then, any employment-based mandate has the greatest impact on those uninsured who have jobs. Many of these may be healthy young workers who value other benefits such as education or additional income over health insurance.

The fact that so many sole proprietors do not carry insurance for themselves suggests that there is no ulterior "sweat shop" mentality at work. Clearly, employers are not perniciously denying their workers health insurance. Instead, the real problem, the problem not addressed by S.1265, is economic. This is highlighted vividly by the fact that so many of the uninsured with jobs, including sole proprietors, work in or operate small businesses.

It is not so surprising. Small businesses typically operate on tight margins of profit. In a highly competitive marketplace like construction, a market where profits are made only by building quality products at the least cost possible, profit margins are especially low, usually about 2-1 before taxes.

In making business decisions, a small business owner relies on a set of priorities. Typically, that would involve a decision about a market for his or her product and the cost of actually producing goods including the cost of the tools necessary to start and materials utilized to complete production. Only then does an employer decide how many workers he or she can afford and what their compensation should be.

In a tight profit situation, any new cost imposed on an employer, including high taxes, paper-laden employee citizenship verification, higher wage requirements, and inflexible new benefit requirements, must be passed on, either through a lower bottom line or new costs to customers. The inability of an employer in a competitive market to pass those costs on to customers means greater pressure to reduce operating costs.

In addition to limited discretionary income, the economies of scale in today's insurance marketplace tips toward large employers with great numbers of workers. Small business owners are faced with paying higher premiums to cover fewer workers.

The approach taken by S.1265 to require employers to offer specific coverages further raises costs for small businesses. Denying an employer any flexibility in determining which specific health benefits are attractive to his workforce needlessly raises his or her costs even further.

The Associated Builders and Contractors has long placed greater employee health care as a primary problem faced by our members. ABC offers access for our members to a competitive group health insurance plan. Our ABC Security Plan offers an array of packages for both management and workers. We are currently in the initial stages of offering a new Health Maintenance Organization (HMO) option in several regional markets. We have always found tremendous member interest in the Security Plan. ABC views this as just one more example that most employers will offer a health package if he or she can economically shoulder its cost.

Though its goal of getting health insurance for more Americans, ABC feels that S.1265 ignores the fact small businesses, particularly construction contractors, do not have unlimited capital to invest on workers. The cost of this legislation, estimated by its proponents as $20 billion, will ultimately result in less employment--only excaberating the problem of uninsurance, not solving it.

ABC believes that S.1265 is an unwarranted intrusion into the voluntary employer-provided benefits system which already works for the vast majority of Americans. It destroys the flexibility essential for an employer who structures his or her employee benefits package to best fit the needs of workers and assure a stable and satisfied workforce.

If Congress is truly interested in attacking this problem, it should focus on the real issue, how best to address the economic problem faced by small businesses.

First, Congress should find ways to reduce the cost of medical care for all Americans. It should also work to increase availability and affordability of health insurance. Though the regional pooling arrangements suggested in S.1265 are worth further study, we should not rush into them, especially armed with the other, more onerous mandate requirements contained in the bill.

Second, Congress should expand the health insurance tax deduction for sole proprietors from 25 percent to 100 percent, as it is for their corporate counterparts.

Third, Congress should create a cost-benefit analysis for employer mandates. Looking at the cost of a single mandate is deceiving when the cumulative costs imposed by the federal government on employers is stifling and in some cases, overwhelming.

Fourth, perhaps the best single action Congress can take to help both employers and unemployed Americans is the enactment of pro-growth economic policies.

ABC appreciates the opportunity to share our views on S.1265 and looks forward to future opportunities to discuss our position in greater detail.

November 3, 1987

The Honorable Orrin Hatch
Ranking Minority Member
Committee on Labor and Human Resources
835 Hart Office Building
U.S. Senate
Washington, DC 20510

Dear Senator Hatch:

On behalf of the American Subcontractors Association, I wanted to take this opportunity express our opposition to S.1265, the Minimum Health Benefits for All Workers Act of 1987. If this legislation were to be enacted into law, many small subcontractors, particularly those in depressed areas of the nation, would not be able to afford to keep their businesses afloat. While ASA supports the goals of the bill, this legislation, as crafted, is far too rigid to be smoothly adapted to all industries.

Since the construction industry has a highly transient and often seasonal workforce which works on a contractual basis, this legislation would be a huge bureaucratic burden, as well as a financial burden for subcontractors. Most subcontractors realize they need to offer a good benefits package to keep a steady and qualified workforce in an industry that is extremely competitive, but S.1265 will only serve to give large companies the ability to push small ones out of the market. It is hardly mysterious as to why some large companies are testifying in favor of the legislation. They see there own costs going down by mandating health insurance, but, more importantly, they see a vehicle which will give them a competitive edge in the market and an easy stranglehold on small businesses.

The problem of the uninsured has not gone unanswered in the construction industry. ASA has been a leader in developing an employee health benefits program which we offer to all of our member companies. Indeed, it is one of the main reasons why many subcontractors across the country have been joining ASA, and over 1,100 companies have done so this year alone. Our plan is recognized as one of the best in the industry, but, in some

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respects, our plan does not meet Senator Kennedy's "minimum" coverage. I fail to see why Senator Kennedy's plan should be automatically judged more suitable for the subcontracting industry, when ASA has carefully researched the needs of the industry and offers a plan which has been tailored to the subcontracting industry. In one fell swoop, our work could be thrown out in favor of Senator Kennedy's idea of health benefits for the subcontracting industry. This outcome is quite disturbing since a politically-designed health care plan is taking precedence over all commercially-designed plans when clearly the responsibility lies with employers who understand their own company's needs and not with politicians who do not. If there is to be a congressional solution to the problem of the uninsured, it should be a positive, incentive-based program geared towards employers who can afford to provide insurance but are not doing so.

This legislation seems to be based on the premise that small businesses do not offer health insurance merely because they do not want to spend the money. In order to stay competitive, most employers will eventually provide health insurance, but only when the business can sustain the additional costs. ASA has recognized this and offers a plan which small businesses can afford and provides substantial coverage to employees. Sponsors of S.1265 are taking a lopsided approach to solving the problem of the uninsured. They are trying to help all employees, but, for many employees, their very jobs could be at stake if the legislation were enacted since marginal enterprises could be forced into bankruptcy.

With the long list of mandated benefits proposals now before Congress, many small businesses are becoming increasingly nervous about their long-term ability to survive in the marketplace. It is indeed unfortunate that sponsors of legislation such as S.1265 should be the cause of additional worry and frustration for the segment of our economy which provides the only real hope for long-term economic growth for the country. It is difficult enough to start a small business, and making it successful is sometimes next to impossible.

ASA would be more than willing to discuss alternatives to mandating health insurance across the board and to discuss the type of insurance we have developed for the subcontracting industry. This is the most logical and sane approach to dealing with the plight of the uninsured worker, and we sincerely hope Congress considers methods other than S.1265.

November 3, 1987
page three

We also respectfully request that our objections to S.1265 be included in the record on this bill.

Sincerely,

Mac Sullivan

M.R. "Mac" Sullivan, Jr.
Chairman
Government Relations Committee

Whirlpool Corporation

Comments On

The Minimum Health Benefits for All Workers Act of 1987

S. 1265 and HR 2508

to the

Senate Labor and Human Resources Committee
House Health and Environment Subcommittee
House Labor-Management Relations Subcommittee

Whirlpool Corporation
2000 M-63 North
Benton Harbor, MI 49022

October 9, 1987

FOR THE LEGISLATIVE RECORD

Whirlpool Corporation
Comments on
The "Minimum Health Benefits for All Workers Act of 1987"
(S. 1265/HR 2058)

Whirlpool Corporation is a world leader in the manufacture and marketing of major home appliances. The company and its U.S. subsidiaries employ approximately 30,000 people, providing them a number of comprehensive health benefit packages costing the company tens of millions of dollars annually. The benefit programs provide for membership in a health maintenance organization (HMO) plan (where available) or a flexible ("Flexchoice") medical plan from which employees choose benefit areas and levels of program coverage consistent with their lifestyle or family needs.

The "Minimum Health Benefits for All Workers Act" (S. 1265/HR 2508) raises a number of specific concerns relative to Whirlpool's health benefit program, as well as its general impact on health care policy for the nation. We offer the following comments for your consideration.

I. Mandatory Participation

1. All employers not already providing a health benefit package that is essentially equivalent to S. 1265/HR 2508 would be forced to establish such a program or purchase a benefit package from a government-certified insurance company.

Many small, emerging companies -- which provide the greatest market for U.S. job growth -- can ill afford to incur additional employee-related costs, particularly those firms struggling on narrow or zero profit margins. An additional layer of expense, without compensating productivity gains to offset the new costs, could force business failures and job losses throughout the economy.

2. The legislation prohibits waiver of participation by employees. First, it's not altogether clear that employees, given a choice, would willingly forego other benefits or wage increases to obtain health benefits. That should be left to personal choice -- not to government mandate.

   Second, mandatory participation makes no sense for multi-worker families where the insurance plan of one spouse protects the other. Duplication of insurance coverage would be a wasteful, inefficient misallocation of personal, business and national resources.

3. The legislation establishes minimum levels of benefit coverage in certain prescribed areas. Those specifications, in effect, presume that America's nearly 113,000,000 workers have homogeneous needs and lifestyles. Demographic trends, however, show differently, pointing to even greater diversity in the workforce in future years. Employees tell us they want more choices in their health plan. With that in mind, and the need to contain spiraling health care costs, more companies like Whirlpool are moving to flexible (cafeteria) health plans to offer employees more -- not fewer -- choices of coverage to meet their special needs.

To the extent the government would intrude into this traditionally private sector matter, it should not mandate program content at the expense of employee flexibility and employers' efforts to control rising health care costs.

4. One area of legislated coverage would be well-baby care, a benefit not currently provided for in our health plans. Besides its cost effect, we seriously question its need for our plans. It's very arguable that pediatric care for our employees' children would be affected merely by adding this new benefit. Also, the legislation offers no rationale why this coverage should be exempt from the 80/20 deductible requirement applicable to other facets of the plan.

II. Competitive and Cost Considerations

1. The Department of Health and Human Services would "certify" from 2 to 5 insurance firms in various regions of the nation to provide programs for companies currently without benefit plans. The creation of a government-created insurance oligopoly is not only objectionable to the free enterprise concept, but will limit price competition essential in an open market economy. Clearly, companies in a protected industry are more prone to program abuse than companies in a competitive environment.

2. The legislation fails to establish limits on usage of health delivery services. Unrestrictive use (e.g., as in well-baby care), without caps or deductibles, will lead to imprudent use and inflationary program cost increases.

3. It has been estimated that the legislation would increase the nation's health care bill by over $100 billion a year -- with no corresponding increase in national productivity. U.S. businesses, already struggling to be globally competitive, and to maintain acceptable profit margins, would have few alternatives but to try to pass through the higher costs to consumers. This action would widen the competitive gap even further, giving foreign producers one more leg up on U.S. industry.

4. Expanding the demand base for health care services, without appropriate program use disciplines, can be expected to spawn a disproportionate escalation in national health care costs for all citizens. As service demand increases, the medical delivery industry will also expand, bringing with it massive increases in costly, high technology.

   Our concern is not in making quality medical care available to more people; but in making it available in an efficient, cost-effective manner.

5. The amounts of the deductibles are not indexed. Over time, inflation will erode their value as an incentive to use health care for truly necessary reasons.

III. Business and Tax Considerations

1. The bill's sponsors advertise the program as a "minimum" health benefits plan. In fact, it is a Cadillac proposal, rivaling many of the generous benefit provisions of some of America's largest industries.

   An independent research institute has pegged the per family, 1988 premium of the Kennedy plan chargeable to employers at $2,314. For many, especially emerging, businesses this added expense would not only be prohibitive, but also become a disincentive for business formation or expansion.

2. Mandatory coverage will force many employers to shift wages into health benefits. This would be especially hurtful to employees of emerging companies which historically have a low wage scale relative to the average national wage level.

3. It is estimated that the shift in taxable wages to tax-favored health benefits mandated in the Kennedy-Waxman plan would cost the U.S. Treasury $35 billion a year in lost tax revenues.

   In an era of Gramm-Rudman-Hollings, passage of this legislation would precipitate additional Treasury and congressional pressure to scale back or eliminate business and/or personal tax deductions for the cost of private health care programs.

4. Mandatory, employer-paid health benefits constitute nothing more than backdoor taxation of the U.S. business community. It's a concerted effort by some members of Congress to force the cost of their favorite social programs on to businesses rather than through the federal treasury where it belongs.

   This philosophy is a major cause of alarm for U.S. industry. If allowed to prevail, the U.S. private enterprise system will not long survive as we know it. America's private sector is financially incapable of being the government's new, bottomless purse to fund every new, social program on the horizon. In the scheme to make America more globally competitive, this proposal would make it less competitive.

Conclusion

Health care for all is laudable. However, in spite of its general appeal, its availability must be efficient, affordable, used wisely, and encourage cost-sharing to insure program controls are in force. Because S. 1265/HR 2508 meet none of these criteria, both bills are flawed and should be defeated by Congress.

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POSITION
OF THE
AMERICAN RETAIL FEDERATION
BEFORE THE
COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE
CONCERNING S. 1265
"MINIMUM HEALTH BENEFITS
FOR ALL WORKERS ACT OF 1987"

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ARF POSITION ON MINIMUM ESSENTIAL HEALTH CARE

The American Retail Federation believes that the Minimum Essential Health Care Act (S.1265/H.R.2508) places an undue burden on the heavily labor-intensive retailing industry, which employs nearly 16 million Americans, a large proportion of them part-time workers.

The inflexible nature of the legislation would force employers in a highly diverse industry to fashion identical health care plans rather than offer the variety of plan options from which retail employees may now choose.

The legislation's mandate that employers would provide, at no cost to the employee, health care plans for low-wage workers further unfairly impacts an industry which has traditionally provided hundreds of thousands of entry-level jobs for youths and unskilled workers.

The American Retail Federation, representing the 51 state retail associations, some 30 national retail associations, and large and small corporate retailers, opposes passage of S.1265/H.R.2508, the Minimum Essential Health Care Act.

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MANDATED HEALTH BENEFITS
Are They Really A Good Deal?

The objective of employer-provided health insurance, while an attractive one, must be addressed in light of a desire to provide full employment, economic growth and increased productivity in American businesses. The interrelated nature of these goals is especially sensitive in labor-intensive industries such as retailing. Increased labor costs effected by federal mandates such as the proposed legislation to require employers to provide rigidly designed employee health insurance programs will, of necessity, result in a diminished choice of other employee benefits, creation of fewer new jobs, and in an increased cost of goods to the consumer.

Large retail companies typically provide generous health insurance packages for employees, although specifics vary greatly among companies. Yet these companies estimate the increased annual cost of compliance with the proposed S.1265 ranges from $130 - $510 per employee. Costs for smaller companies not currently providing health benefits will be significantly higher and the aggregate impact on the retailing industry which employs nearly 16 million Americans will be staggering.

The proposed legislation provides no opportunity for employers to alter health care coverage to meet changing conditions; rather it cites rigid standards for coverage, deductibles and co-payments. It requires low-income workers (above $4.19/hr.) to accept partial responsibility for payment of a benefit they might otherwise not elect. And it allows no alternative response to escalating health insurance premiums and provider costs.

The American Retail Federation continues to support the voluntary provision of generous and reasonable fringe benefits for the Nation's retail employees.

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TESTIMONY OF

THE RISK AND INSURANCE MANAGEMENT SOCIETY, INC.
(RIMS)

SUBMITTED BY

HOWARD W. GREENE
ASSOCIATE LEGISLATIVE DIRECTOR
RIMS

TO

THE LABOR AND HUMAN RESOURCES COMMITTEE OF THE UNITED STATES SENATE ON S. 1265, THE MINIMUM HEALTH BENEFITS FOR ALL WORKERS ACT OF 1987, HELD ON NOVEMBER 4, 1987 IN WASHINGTON, D.C.

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IFRIMA

Hello, my name is Howard W. Greene and I am the Associate Legislative Director of the Risk and Insurance Management Society, Inc. (RIMS). RIMS is a non profit professional/trade association which represents 7,400 risk and employee benefit managers from 4,000 corporations, institutions and public entities. Our membership ranges from the Archdiocese of Baltimore to Fortune 1,000 companies, 90 percent of which belong to RIMS.

We take great interest in the "Minimum Health Benefits For All Workers Act of 1987" for both the promise it may hold and the danger it may pose. In principle, RIMS does not object to the approach being taken in the bill. Although we are wary of any mandated employee benefit proposal, we do not reject the legitimacy of such proposals on ideological grounds. We base this attitude on the realization that a special relationship exists between employer and employee where health coverage is involved. RIMS therefore sees a logical nexus at the root of this legislation. However, we caution against an expansion of this principle into a deep-pocket formula in which the employment structure is used simply as a funding mechanism. Our comments are based solely on the legitimacy of the former rationale, not the financial convenience of the latter.

RIMS acknowledges that a problem exists in the United States in the area of uncompensated care, effecting all segments of society. Our concern is that a bill such as this must address a significant number of these cases. We have been told by supporters of S. 1265 that 24 million working Americans and their dependents are without basic health coverage. RIMS does not dispute this number but urges that this Committee make sure the minimum health approach accomplishes the desired objective.

For example, let us be sure we know who the 24 million are. Is the number comprised mostly of part-time workers, seasonal workers or employees in particular industries? How large are the employers not currently offering coverage? Ten or less employees, 20, 50? Is the main problem lack of insurance or inadequate insurance? The design of any proposal should be directly related to the answers.

For the purposes of these comments, RIMS has assumed the minimum health approach does indeed address a significant part of the problem. As a result, our comments are aimed almost exclusively at the incongruence between the stated aim of increased access to health coverage and the specific requirements of the bill. We believe the use of the word "minimum" in the title demonstrates an intent to make this a basic approach without flourishes. Supporters have often said the plan required by the bill is not a "Cadillac" plan. RIMS must disagree.

Under the current provisions, an employee who works 17 1/2 hours a week would be entitled to health coverage 30 days after his or her first hour of work. We believe both time frames must be increased. The present requirements would cover part-time seasonal workers with minimal ties to the employer. Providing them with health coverage would inordinately increase the cost of hiring a pool of workers whose place in their respective industries is based on cost efficiency.

Both triggers should be increased enough to exclude part-time and seasonal workers because they have, by their nature, a tenuous relationship with their employers. The present language would wreak havoc with many of the employer plans already in force. Since the stated intent of the bill is to require employers not currently providing coverage to do so, RIMS views these time frames as excessive. As the bill is being advertised to employers who do provide coverage as a way to level the playing field, such low triggers only serve to confuse our membership, which insures millions of workers, about the true purpose behind S. 1265.

Lengthening these triggers will probably not have a harsh effect on covering uninsureds. Many part-time workers are supplemental wage earners who are covered under a spouse's plan or, in the case of students, a parent's plan. They already receive protection without endangering the economic efficiency of their positions.

Second, although the bill holds an employer responsible only for a covered individual's reasonable charges, we would like to see a provision which states that the out-of-pocket limits on employee co-payments and deductibles can only be reached through employee expenditures which comply with the plan. For example, if the plan requires a second surgical opinion and a covered person fails to obtain one, any co-payment or deductible penalty which the individual pays under the plan would not apply toward the limit. This is an equitable, common sense form of cost containment which is a standard assumption of many plans.

Third, all pre-existing conditions would have to be fully covered under the current provisions. This is not a standard feature of most group health plans and would likely prove very costly to employers. Again, if we wish to afford uninsured people coverage and not impose a wish list on presently offered plans, some type of limitation is necessary. Perhaps a dollar cap or waiting period would offer some protection without exceeding the bill's mandate.

Next, S. 1265 would treat dependent coverage the same as employee coverage for purposes of premium contribution. Again, RIMS questions whether this provision is minimum coverage. Although there is a nexus between an employer and its employees' dependents, the tie is much looser than that between employer and employee. Interestingly enough, unmarried employees may cry discrimination, as they sometimes do in this situation. After-all, doesn't this bill mandate an additional benefit only for married employees? We therefore suggest that employers be required to pay a significantly smaller percentage of dependents' premiums. The goal of access to coverage would remain intact while keeping employers' costs at a more reasonable level.

Fifth, S. 1265 would require that prenatal and well-baby care be afforded 100 percent, first dollar coverage. We understand why such importance is being place on these coverages and we do not argue with their inclusion. However, RIMS does not agree with the special treatment given prenatal and well-baby care. The all expense-paid approach is a costly mandate which goes beyond the 1978 amendments to the Civil Rights Act. Those amendments require that pregnancy be treated like other covered medical conditions. A minimum plan must certainly meet the civil rights standards but mandating an expansion of those standards is excessive.

There will also be some administrative problems with the prenatal and well-baby provisions as they now stand. For example, if prenatal care is covered at 100 percent while child delivery is covered at 80 percent, employers will need a breakdown of how much the prental care for an individual cost and how much her delivery cost. Since physicians currently invoice a lump sum without a breakdown, physician billing procedures will also need to be mandated if the bill is to be given practical effect.

As for well-baby care, RIMS suggests a cost containment measure be inserted, such as a list of covered expenses. This should be put right into the bill and might replace the current provision, which allows the Secretary of Health and Human Services to make these determinations yearly. Such annual changes will make it very difficult for employers and insurers alike to plan in advance, thereby interfering with their ability to maintain stable coverage.

RIMS must also voice concern about the section which mandates free insurance for employees earning less than 125 percent of minimum wage. This would greatly increase the cost of such workers to employers and it is these workers who tend to be employed because of economic efficiency instead of marketable skill. The bill's requirements may significantly decrease the economic efficiency of hiring these unskilled workers thereby leaving employers little choice but to reassess their workforces.

We would like to see one other area of plan design changed slightly. The legislation indexes the out-of-pocket limit on a yearly basis. RIMS recommends the same be done with deductibles in order to keep the relative value of the plan somewhat consistent from year to year.

Shifting to a more general overview, RIMS does not agree with forcing employees to take coverage. While we understand there is some concern that employers may not hire or may actually fire employees who choose to take coverage under an optional system, we believe this would amount to only a few irresponsible employers. Insurance is often an option and new employees usually do not choose until after they are hired. The mainstream of American employers already handle the issue responsibly and our members must object to being treated as doing otherwise. Although coordination of benefits helps to guard against double dipping by employees, this far from perfect approach depends on employees telling employers about duplicate policies. Mandatory acceptance may therefore lead to an unnecessary increase in costs.

Not allowing the employee to waive enrollment even when covered under another plan is also a detriment to cafeteria plans. These increasingly popular plans allow an employee covered under a spouse's policy to choose other benefits which are more individually suited to his or her particular situation, such as increased life insurance or child care expenses. Forcing the employee to take his or her employer's plan may eliminate this valuable option.

With all the disadvantages of removing employee choice, RIMS submits that a better way to alleviate employment discrimination fears is to expand Section 302 (c) of the bill. That section already prohibits such discrimination against an individual based on his or her spouse or children's need to be insured. We suggest this section be amended to cover the employee's choice about health insurance as well.

RIMS must also express discomfort with the regional insurers system proposed in the bill. This not only takes the freedom to contract away from employers but also hurts smaller insurers, who are often more attuned to local markets than large carriers. The smaller insurers may not be able to compete on a regional basis. Enactment of S. 1265 will create a whole new market for insurers and we believe they will step in and fill the need, making the regional scheme unnecessary.

From an insurance consumer's point of view, we must also express some confusion about congressional policy objectives. The regional insurer system sets up monopolies and effectively eliminates competition. At the same time, the Senate is considering a scale back of the insurance industry's anti-trust exemption under the McCarran-Ferguson Act. The reason for reformation, we are told, is to increase competition. There seems to be a conflict here. Which policy objective are we to believe?

Lastly, the final section of S. 1265 indicates that as a matter of intent, the bill wishes to discourage other benefits from being added to the legislation after passage. RIMS strongly agrees with this policy and believes this point to be of great importance. We therefore recommend this intent be made clear by stating that no benefits may be added once the bill becomes law. Although we realize future congresses may change such a provision if they wish to add benefits, the legislation would leave no doubt as to intent and would open the process to public scrutiny.

RIMS believes all these proposed changes to S. 1265 are consistent with the bill's purpose and would provide the desired benefit in a less expensive and more equitable way. At the same time, the legislation would be more palatable to the employer community. If the minimum health approach is indeed shown to be the most effective way of dealing with our nation's health insurance problems, then let us get on with the solution. But let us also make sure the solution does not become the problem.

Thank you.

Statement of the National Grocers Association

BY: RICHARD CRAWFORD
DIRECTOR OF GOVERNMENT AFFAIRS

ON: S. 1265, THE MINIMUM HEALTH BENEFITS FOR ALL WORKERS ACT OF 1987

TO: SENATE LABOR AND HUMAN RESOURCES COMMITTEE

DATE: NOVEMBER 16, 1987

The National Grocers Association is the national trade association representing over 2,000 members of the small business sector of the food distribution industry. Retail and wholesale grocers hold full membership in N.G.A.; state/local associations and manufacturer/suppliers hold associate membership in N.G.A.

I. INTRODUCTION

The National Grocers Association (N.G.A.) is pleased to have this opportunity to submit this statement on the "Minimum Health Benefits for All Workers Act of 1987," S. 1265, introduced by Senators Edward Kennedy (D-MA) and Lowell Weicker (R-CT).

The National Grocers Association represents the small business sector of the food distribution industry, including over 2,000 retail grocery firms and 60 wholesale distribution companies. N.G.A.'s retail members operate convenience stores, conventional supermarkets, and superstores. N.G.A.'s sixty wholesale food distribution centers distribute food and grocery products to retail grocers in all 50 states.

Independent food retailers and wholesalers have served the American consumer for over 200 years. They account for 64% of all grocery stores in the United States and are responsible for distributing nearly one-half of the grocery products in the U.S. As an integral part of the American economy, independent food retailers and wholesalers employ between 1.3 to 2.0 million Americans.

II. DESCRIPTION OF S.1265

S. 1265 and its companion House bill are intended to reduce the number of Americans without health care coverage by requiring every employer in the nation, as a cost of doing business, to provide comprehensive health care coverage to all employees working a minimum of 17-1/2 hour per week and their families from the thirtieth day of employment. Enactment of S. 1265 would establish a system whereby the federal government would dictate the design and content of health plans; and employees and their families would be compelled to accept the plans. These plans must include medically necessary Hospital Care, Physician Care, Diagnostic Tests, Pre-Natal Care, Well-Baby Care, and Catastrophic coverage limiting out-of-pocket family costs for covered services to $3,000.

Deductibles may not exceed $250 per individual and $500 per family except for pre-natal and well-baby care, for which no cost-sharing may be imposed. It also limits co-payments from employees to twenty percent of the cost of any service. Employers must pay eighty percent of the premium; however, for low wage workers (under 125% of minimum wage) employers must pay the full premium.

Finally, the bill provides a regional insurance carrier which offers a structured choice of a limited number of coverage plans in a particular area or state for small businesses which cannot secure coverage through conventional means. The bill also requires that an employer with twenty-five or fewer employees who do not have coverage on the day the law is enacted must obtain coverage from the regional carrier.

The sponsors' original intentions for providing regional carriers would be to provide a vehicle to ensure the access and availability of coverage for small businesses not able to purchase the coverage and to ensure that a wide variety of insurance companies could compete and provide the best coverage at a reasonable cost for each individual. The government would certify regional carriers to provide such insurance. We believe this regional carrier provision in the bill, which mandates small employers to participate in the program, is a flawed concept which will impede private competition and limit the employer's choice among competing insurers.

III. N.G.A. POSITION

N.G.A. and its members recognize the importance of health care. However, let us clear up some fallacies relating to the issue. It has been generally accepted that there is a pool of some 32 million persons uninsured in this country. However, according to the "State of Small Business," June, 1987, a report prepared by the office of advocacy, approximately 20 million of the 32 million Americans currently uninsured are either non-workers or are temporarily in a job-transition situation.

It should also be pointed out that a majority of the large and small businesses in the United States already offer employer-based insurance plans to their employees. In fact, the private sector spends over $105 billion to insure 130 million persons each year. Furthermore, the share of gross payroll spent by employers on health benefits has increased fifty percent between 1976 and 1983.

N.G.A. vigorously opposes the proposed legislation as a solution to the health care crisis in this country. We believe that enactment of S. 1265 is not the appropriate solution. S. 1265 may harm food distribution industry employers and employees alike by: (A) causing further escalation in health care costs; (B) increasing costs of goods and services; (C) actually decreasing coverage for employees already participating in employer plans; and (D) discouraging new hiring.

A. Escalation in Health Care Costs

The bill's sponsors have estimated the cost of the legislation between $25-30 billion. We believe these numbers are unrealistically low estimates. There have been many discussions and many proposals submitted on the aggregate cost of the legislation. Even so, we are convinced that even the bill's sponsors do not know the magnitude of the economic impact on business if S. 1265 were enacted. However, we do know that initial studies indicate that the economic impact of such legislation on smaller businesses throughout the United States could be extremely adverse. The Institute of Research on the Economics of Taxation (IRET) estimates that the legislation will increase private insurance costs by $100 billion the first year and will lead to a $35 billion loss in federal income and social security tax revenues due to the decreases in salaries and hours.

If S. 1265 is enacted, group medical plan expenditures, according to Business Insurance Magazine, August 7, 1987, could increase 24 to 70 percent, depending on the employer's contributions for dependent coverage. For example, a grocer from Mansfield, Pennsylvania reported that currently he pays 100% of premiums for employees. If he were forced to start paying for dependents he would require the employees to start paying a portion for their own coverage. Additionally, he would drop the "extras" he is now offering like prescription drug coverage, sick leave, dental leave and eye glass plans.

The bill sets twenty percent of the monthly cost as the maximum employee contribution to coverage. Many food retailers and wholesalers pay 100% of the cost of a full-time employee's coverage and require the employee to pay between 30% and 100% of the cost of dependent coverage. A grocer from Des Moines, Iowa said requiring coverage of all employees working 17 1/2 hours or paying 80% of premium would increase his costs by 85% and would reduce his anticipated pre-tax profits by 10%. Of course, cost increases would vary according to employer contributions for workers and dependents.

B. Increasing Costs of Goods and Services

The National Grocers Association has undertaken a comprehensive study of a substantial segment of its membership to document the costs of implementing S. 1265. We received 217 responses from retailers whose companies operate 493 stores and employ over 21,378 workers nationwide. The average retailer in the survey owned approximately two stores and employed some 43 workers. We believe that the results of the survey clearly outline the prohibitive costs associated with this legislation.

A summary of the preliminary results of that study reveals that on both a per store and per company basis the average increase in labor costs imposed by the proposed legislative mandates would be 9.74%. In a significant number of cases the resulting labor cost increases would be much greater and more burdensome, especially because of the number of entry-level wage positions that are so common in food retailing.

Survey results also showed that passage of the mandated health insurance bill as currently written would cost each company, on the average, an additional $41,400 annually to insure their entire labor force. That equates to almost $9 million annually for all uninsured employees of the 217 companies polled in the study.

For the moment, lets accept the initial cost of $30 billion (estimated by bill sponsors) to implement S. 1265. The $30 billion price tag will not disappear because employers pay it. The majority of the costs will be reflected in the price of products purchased by consumers. One survey question says, "How would you respond operationally if required to buy insurance for all employees working more than 17 1/2 hours per week?" An overwhelming 75% responded by saying they would pass costs along to consumers.

A comment from a grocer from West Point, Nebraska, reflected this consensus: "I would raise my cost of goods sold and thereby increase retail costs."

C. Decreasing Coverage From Employer Plans

Seventy-seven percent of those companies polled offer health benefits to full-time workers. Industry practice has traditionally distinguished part-time employees as those working an average of 30 hours or less per week. It is not uncommon for retailers to employ 40 to 50 percent of their employees on a part-time basis. This is necessary to respond to fluctuations in consumer demand.

As previously stated, under S. 1265 the employer would be required to provide coverage for all employees, working a minimum of 17-1/2 hours per week from the thirtieth day of employment. This legislation would lower employment hours and employment opportunities for marginal employees and would increase labor costs substantially for those part-time employees artifically reclassified as full-time employees. Those additional costs would be imposed by governmental mandate without any offsetting increase in productivity. For smaller food retailers and wholesalers with less generous health plans, the cost would be proportionally greater. Their response to mandated health insurance would be to cut back other benefits, and drastically cut back on staff and work hours for existing staff.

We posed two questions to our respondents in the survey by asking them, "if S. 1265 were enacted: Would you, a) eliminate or reduce part-time employees? Or, b) consolidate part-time positions into full-time positions? Our survey showed that 76% of employers would, for most, if not all, their part-time employees (average 20-30 hours per week) cut their hours to 17 or less hours per week to avoid the bill's provision; 53% said they would transfer full-time employees to less than 17 hours a week. Obviously, these cut-backs in the work force will ultimately hurt the very individuals this legislation hopes to help.

In addition, many companies in the industry hire employees on a probationary basis. This means that an employee must work on a trial basis for a time period of 60 days, for example, before he or she is eligible for benefits, profit sharing etc.

According to the N.G.A. survey data, over 92% of the companies polled have this type of hiring procedure. The probationary period ranges from 30-90 days. Probationary periods serve to contain health insurance costs by avoiding short term coverage and unknowing coverage of preexisting conditions.

S. 1265 would virtually eliminate such probationary practices. Such employees would be covered under the Kennedy Bill from the thirtieth day of employment at the company and be entitled to the COBRA continuation coverage passed last year, at his or her own expense for 18 months after employment ends.

The increased payments for mandated health care will force food retailers to redirect limited resources from wages to health benefits. It also means fewer dollars for other benefits now being offered by food retailers and wholesalers, such as pensions, vacations, flex-time, profit sharing and other programs.

N.G.A. strongly believes that a voluntary, flexible and comprehensive benefit system should be negotiated between employers and employees. Mandated benefits impose substantial burdensome costs on employers and should not be dictated by acts of Congress. N.G.A. recognizes the concerns addressed by Congress in providing adequate health care to all Americans. But just as the federal government must restrain itself in implementing new spending programs because of the massive budget deficit, businesses must also operate within budgetary constraints which assure continuation of employment, business operations and profitability. It is unjustified for Congress to mandate the private sector to pick up the tab for health insurance.

D. Discouraging New Hiring

In todays' marketplace, food retailers and wholesalers attract competent employees by offering competitive wage and benefit packages which include one or more of the following: wages, health insurance, parental and medical leave, retirement plans and flex-time. Because the food industry is so labor intensive, (with the average supermarket profit margin at less than 2%), management must have the flexibility to determine what specific types of wage and benefit compensation plans they can offer and still stay in business. While one objection is to the direct dollars and cents cost of the program to employers, our concerns also lie with the interference in the smooth operation of our members' businesses, resulting threats to the health of the businesses, and the potential for unemployment if they go out of business.

The independent retail grocer faces an array of fierce competitors vying for the market share of the industry. The independent retail grocer today is forced to compete with not only large supermarket chains but outside competition from fast food restaurants such as McDonalds and others, who are offering entry-level wages of $4.00-$6.50 per hour. According to Progressive Grocer's 1985 Annual Report of the Grocery Industry, fast food restaurants were ranked as the supermarket's strongest "outside competitor."

These market conditions demand that food retailers provide strong and attractive benefit packages in order to attract employees. Such benefits are offered not because they are required, but because it is a sound business practice. A voluntary comprehensive benefit package strengthens the food retailer's ability to compete with his or her competitors.

If S. 1265 is enacted, all those employees working 17 1/2 hours per week will be covered under the act's provision. As we indicated before, the typical part-time food retail employee works between 20 and 30 hours per week. Approximately two-thirds of the food retailing work force is part-time. The industry has traditionally attracted large numbers of high school and college students and second-wage earners. However, most of these part-time employees are covered under their parents' or spouses' insurance plan. Duplication of insurance coverage would be a wasteful and inefficient misallocation of business resources, and would add substantially to the already skyrocketing cost of health insurance.

For many employees, their very jobs could be at stake if the legislation were enacted since many small grocers would be forced into bankruptcy. A grocer from Madison, Wisconsin who employees 50 to 60 university students during the school year, said that enactment of S. 1265 "Would make me totally uncompetitive, because most of the competition in the area have union contracts which has them providing insurance for all employees. If I pass along any increased costs, or part of them, my prices would be totally out of line. Also, I would have to eliminate several positions which would put many people out of work. Possibly some of those 50-60 students would not be able to continue their education if jobs were eliminated or consolidated."

In sum, mandated benefits as described in S. 1265 are likely to hit hardest at those who most need employment and where higher wages are likely to be preferred to a duplication of insurance.

IV. CONCLUSION

A business that is not competitive simply cannot survive and, obviously, cannot provide jobs for the community. As Beryl Sprinkel, the Chairman of the President's Council of Economic Advisors, pointed out recently in the Washington Post Opinion section, many European nations that enacted mandated benefits almost a decade ago now are economically stagnant. Mandated benefits are not the only reason these countries have fared poorly, Sprinkel argued, but they are important elements in Europe's rigid labor market. It is ironic Sprinkel said, "That benefit mandates are being proposed here just as many other countries are attempting to reverse such failed policies."

On the other hand, in the United States, small business has been the most dynamic sector of our economy. Virtually 70%-80% of all jobs have been created within the small business community. It is in the best interest of our country for Congress to support this dynamic sector by providing a flexible and competitive environment that encourages economic growth, rather than dictating specific benefits that would stifle the economy. Policies which adversely affect the American economy can hardly be in the best interest of the American work force.

N.G.A. believes that Congress should focus on creative, alternative approaches to mandated health insurance, and on testing of methods to stimulate their use by American businesses.

For example, the recent trend towards "cafeteria-style" benefit plans allows employers to offer employees a menu of benefits from which to select. Employers have made advances in employees' fringe benefit plans by offering flex-time and benefit plans which allow employees to "bank" benefits. This has advantages for employers and employees alike. The employee is able to make choices to meet his or her individual needs while the company can control costs.

The array of employment-oriented legislation now pending before Congress is a threatening cloud on the horizon for small business. In addition to S. 1265, Congress is currently considering increasing the minimum wage, mandating a parental and medical leave package to all employees, and requiring advance notice of a store/plant closing, to name a few. Any one of these initiatives if enacted by Congress will harm small business. Collectively, these proposals will be disastrous and will result in high unemployment, lower growth rates, and a substantial increase in business failures.

We believe our federal labor laws are intended to give employers and employees the freedom to negotiate labor/management issues, not deprive them of that freedom.

N.G.A. RETAILER SURVEY ON THE MANDATED HEALTH BENEFITS

A

TOTAL RETAILERS COMPANIES IN SURVEY:	217
TOTAL STORES IN SURVEY:	493
AVERAGE NUMBER STORES PER COMPANY	2.27
AVERAGE NUMBER OF UNCOVERED SINGLE EMPLOYEES PER COMPANY:	25.53
AVERAGE NUMBER OF UNCOVERED MARRIED EMPLOYEES PER COMPANY:	15.34
AVERAGE NUMBER UNCOVERED SINGLE EMPLOYEES PER STORE:	11.23
AVERAGE NUMBER UNCOVERED MARRIED EMPLOYEES PER STORE:	6.75

B

TOTAL NUMBER OF UNCOVERED SINGLE EMPLOYEES TO BE COVERED IF BILL IS IMPLEMENTED:	5,539
TOTAL NUMBER OF UNCOVERED MARRIED EMPLOYEES TO BE COVERED IF BILL IS IMPLEMENTED:	3,328
TOTAL NUMBER OF ALL UNCOVERED EMPLOYEES TO BE COVERED IF BILL IS IMPLEMENTED:	8,867

C

TOTAL ANNUAL COST FOR SINGLE EMPLOYEES @ $642 EACH:	$ 3,556,038.00
TOTAL ANNUAL COST FOR MARRIED EMPLOYEES @ $1,631 EACH:	$ 5,427,968.00
TOTAL ANNUAL COST FOR ALL EMPLOYEES PER YEAR:	$ 8,984,006.00

D

AVERAGE ANNUAL COST FOR SINGLES PER COMPANY:	$ 16,387.27
AVERAGE ANNUAL COST FOR MARRIED PER COMPANY:	$ 25,013.67
TOTAL AVERAGE ANNUAL COST PER COMPANY PER YEAR:	$ 41,400.94

E

AVERAGE ANNUAL COST FOR SINGLE PER STORE:	$ 7,219.06
AVERAGE ANNUAL COST FOR MARRIED PER STORE:	$ 11,019.23
AVERAGE ANNUAL COST PER STORE PER YEAR:	$ 18,238.29
AVERAGE PERCENTAGE INCREASE IN TOTAL LABOR COST PER COMPANY PER YEAR:	9.74%

HOW TO READ THIS REPORT

Block A, Line 1	See Report #9, Item A1
Block A, Line 2	See Report #9, Item A2
Block A, Line 3	See Report #9, Item A3
Block A, Line 4	See Report #9, Item A4
Block A, Line 5	See Report #9, Item A5
Block A, Line 6	Block A, Line 4 divided by Block A, Line 3
Block A, Line 7	Block A, Line 5 divided by Block A, Line 3
Block B, Line 1	See Report #9, Item B1
Block B, Line 2	See Report #9, Item B2
Block B, Line 3	Block B, Line 1 plus Block B, Line 2
Block C, Line 1	Block B, Line 1 times $642
Block C, Line 2	Block B, Line 2 times $1,631
Block C, Line 3	Block C, Line 1 plus Block C, Line 2
Block D, Line 1	Block C, Line 1 divided by Block A, Line 1
Block D, Line 2	Block C, Line 2 divided by Block A, Line 1
Block D, Line 3	Block D, Line 1 plus Block D, Line 2
Block E, Line 1	Block D, Line 1 divided by Block A, Line 3
Block E, Line 2	Block D, Line 2 divided by Block A, Line 3
Block E, Line 3	Block E, Line 1 plus Block E, Line 2
Block E, Line 4	See Report #9, Item E4 (result of Report #9, F1/A1)

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                                                                  Report Date : 07/29/87
        ==================================================================================
                                      S U R V E Y   T O T A L S
        ==================================================================================

        #STORES      1.          4.-0-    5.          6.INDIVIDUAL  8.$642X              9a.
        #EMPLOYEES   2.          4.-30-               6.FAMILY      8.$                  9b.
        Y/N          3.          4.-60-               7.INDIVIDUAL  8.$1631X             9c.
                                 4.-90-               7.FAMILY      8.$
                                 4.OTHER              8A.           TOTAL
        ========     ========    ================     ============= ==============       =
        ---------    --------    ----------------     ------------- -------
  (A2)→  493            18383         666      539     14385              5539 ←(B1)
          21378          2629        2485               11626
                         9075        1443                131,463.13       3328 ←(B2)
                                     3043                 224,503.61
                                     1437       (F1)→ 2113.37
        ========     ========    ================     ============= =======
        Grand Total
  (A3)→ A 2.27          84.71        3.07      2.48    66.29             25.53 ←(A4)
           98.52        12.12       11.45              53.58
                        41.82        6.65                     605.82     15.34 ←(A5)
                                    14.02                    1,034.58
                                     6.62       (E4)→  9.74
  (A1)→ Averages for [217] Records
           All Retailers
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GROCERS-PEC
POLITICAL EDUCATION COMMITTEE

June 2, 1987

GROCERS-POLITICAL EDUCATION COMMITTEE
SURVEY ON HEALTH INSURANCE COVERAGE

Senator Edward Kennedy (D-MA) has introduced legislation, S. 1265, to require employers to provide health insurance coverage from the first day of employment. Employers would be required to co-pay at least 80 percent of the insurance. Health insurance plans could not provide for deductibles that are larger than $250.00 for individuals and $500.00 for families. Small businesses with less than 25 employees would be permitted to join regional insurance pools.

A report requested by Senator Kennedy from the Actuarial Research Corporation estimates the contribution cost to each employer, i.e., your cost of coverage at $642 annually for a single individual and $1,631 annually for family coverage.

The N.G.A. Grocers Political Education Committee is conducting this survey to determine the general practices of the industry in providing health insurance coverage to employees. Your assistance would be most beneficial to us. The data collected by the Grocers-Political Education Committee survey will be compiled for an industry report to Congress and circulated to members of the industry. If sufficiently comprehensive, it can have a real impact upon shaping Congressional attitudes. Please complete the following survey and return it to National Grocers Association.

GENERAL INFORMATION

Name:______________________________

Company Name:______________________________

Address:______________________________

City, State, Zip Code:______________________________

Phone:______________________________

Number of Stores:______________ Total Number of Employees:______________

Is your company covered by a collective bargaining agreement?______________

Grocers-Political Education Committee
1825 Samuel Morse Drive, Reston, Virginia 22090 703-437-5300

Mark N/A if the answer is not applicable

1. How many of your employees are normally employed 17 1/2 or more hours per week? ____________

2. How many of your employees are normally employed less than 17 1/2 hours per week? ____________

3. How many employees normally employed 17 1/2 or more hours per week do you provide health insurance coverage for? ____________

4. Of the employees eligible for health insurance, do you require a waiting period? Fill in how many employees must wait for each specified period. (For example part-time workers working more than 17 1/2 hours per week may have a different waiting period than full-time employees.)
   ________0 days
   ________30 days
   ________60 days
   ________90 days
   ________other______

5. How many of your employees, if any, are required to pay a deductible greater than $250 per single individual or $500 for family coverage? ____________

6. What percentage of the annual premium for health insurance do you (employer) pay for?
   ______% individual
   ______% family

7. What is your (employer's) average cost per covered employee per year for health insurance coverage?
   $______ individual
   $______ family

8. In calculating your annual cost of the proposed mandated health insurance coverage, please utilize the following figures for currently uncovered employees who normally work at least 17 1/2 hours per week:

   $642 x ______ (no. of single currently uncovered employees) = $ __________

   $1,631 x ______ (no. of currently uncovered married employees) = $ __________

   Total = $ __________

8a. What percentage increase in your total labor cost would this equal? __________%

9. How would you respond operationally if you would be required to buy a health insurance program for all employees working more than 17 1/2 hours per week?

A. Eliminate or reduce part-time employees? Yes______ No______

B. Consolidate part-time positions into full-time positions? Yes______ No______

C. Pass the cost along to consumers? Yes______ No______

D. What additional impact would these added costs have upon total operations? ______________________________

____

____

____

10. Additional Comments: ______________________________

____

____

____

____

____

____

PLEASE COMPLETE AND RETURN TO:

NATIONAL GROCERS ASSOCIATION
Thomas F. Wenning
Senior Vice President and General Counsel
1825 Samuel Morse Drive
Reston, Virginia 22090

SURVEY CONDUCTED

by

National Candy Wholesalers Association

NCWA is the leading national voice of the country's wholesale-distributors of confectionery, tobacco, and allied products. It serves over 2,300 members and associate supplier/broker members throughout the country.

178 Responses

SURVEY

Health Insurance Coverage

1. Do you provide health coverage for your employees? 84% YES 16% NO

2. Do you provide health coverage for their dependents? 72% YES 28% NO

(Please return this survey even if the answer to both questions is NO. Thank you).

3. If you answered YES to Number 1, What is the average premium per employee per month? $ 85

4. If you answered YES to Number 2, What is the average premium per family per month? $159

5. What share of the premium do you (employer) pay? 78%

6. What is the deductible? 183 per employee 396 per family

7. What is the total monthly insurance payment made by the business? $3018

8. What is the nature of the insurance (e.g. Blue Cross/Blue Shield, HMO, PPO).
60% Blue Cross/Blue Shield

9. What are the principal features of the coverage?

2% Hospitalization/Surgical Only

4% Major Medical Only

92% Hospitalization/Surgical and Major Medical

________ Don't Know

10. How many employees are covered?

Employees	Companies
1-10	30%
11-20	29%
21-30	12%
31-40	15%
41-50	3%
51-60	5%
61-70	1%
81-90	1%
91-100	3%
111-120	.05%
180+	.05%

11. How many additional employees work at least 17 1/2 house per week?

Employees	Companies
1-10	76%
11-20	11%
21-30	6%
31-40	3%
41-50	3%
51-60	1%

12. Do you provide other benefits?

Paid Vacation	1 week	18%
	2 weeks	58%
	3 weeks	14%
	4 weeks	9%

Life Insurance _73%_ YES _27%_ NO

13. If you were required to provide health coverage to all employees, do you have any observations about the impact on your business?

____

____

____

13. If you were required to provide health coverage to all employees, do you have any observations about the impact on your business?

It would be a financial drain. I resent Congress meddling with any more mandatory requirements. Most of them don't know what it takes to operate a profitable business. Uncle requires too much of us now.

It gets more expensive every year to carry their coverage, making more difficult to show a profit for our corporation.

"Business" does volunteer to cover all.

Only if the government is the Insurer & if then, we'll close up.

Very little impact.

It's got increasingly more expensive over the years.

I would probably go to a less comprehensive coverage.

We have many part time employees, full time employees who don't need health coverage because a spouse is covered. We would probably have to make adjustments on base pay to make up tor the loss on wastful coverages.

If the requirement is to pay 100% of premium for all employees it would require an increase in margins to pay for this added requirement.

If we had to pay the total premium it could cause a hardship with our overall low margin of profit.

Cost would be not real large as we have very few part time people.

It would double our cost. Some employees would have double coverage because they are covered by spouses.

It would put a financial burden that would be hard to overcome.

I really don't see how small business can absorb all the required expenses as it is.

If this were a requirement it would cost us an additional $9000 per year. This in itsel would be something to look at in terms of competetive insurance rates. It could also mean a reduction of Benefits for the employee.

It would reduce the profitability of the company.

With current costs of Workman's Comp and other insurances, impact would be devastating.

Based on percentages, it would reduce other profit or increase our loss (depending on how good or bad a particular year was) by about $2,868.

We're paying as much as we can afford to pay now.

Would like to see a good group policy - your business insurance package.

Yes, we are considering discontinuing our health coverage due to harsh economic situation in LA - To be forced to continue it would be crippling.

Would cut into profits considerably.

Extremely difficult - financially. Economy is severly depressed even the unions are humble - Now comes the government.

It could be difficult.

We tried for many years to provide health insurance, our group was small and some had insurance thru their wives employers. We finally gave up and now pay each $100 in lieu of insurance which of course is taxable to him. At the time we started this would have provided individual coverage.

Small business simply cannot afford such ridiculous expenses. Bills as these will eliminate small businesses and you & I voted for those characters.

Added overhead.

Union requires pension/welfare.

Very large expense and we must try & do something to reduce the expense.

The immediate impact would make our business and other businesswith low mark-up bankrupt. The more overhead expenses are created, the less possibility of survival in this rat race market.

Provided now but rising costs may cause future changes.

Note: we partially self-insure up to $5000 per participant & $10,000 per family annually.

Lower employee turnover.

We do for all that request it.

We already provide health coverage to all.

Very little impact since we have only one part-time employee who is not covered.

I will continue to use sub as long as possible.

Most employees are already covered.

Necessary.

Yes- presently considering charging each employee 20% of his or her policy costs.

Don't want to be required to do it.

Expenses would increase somewhat.

We do provide for all employees.

Yes, it hurts, when operating on a low profit business such as tobacco & confectionery.

The balance of our employees are covered under a union contract - The cost of which is ridiculous.

Seriously cut down on part time employees.

Expensive.

Approx. $38000 Annual costs.

No noticeable change at this time, as only two employees are not covered.

Same.

Little impact as we employ few part-time people. All other get insurance & profit sharing benefits.

For this size company, it is a very benefit.

It would be quite an expense, I think prohibitive, as we are a small firm in a depressed area.

Not doubt it would be costly.

Very negative - What happened to free enterprise?

If we are allowed to split the premium as we now do, it will be an expense we can handle if the premiums do not advance too much. Our plan is offered to each worker - we pay 50% of the premium - for the best plan BC/BS offers. I do believe that no company should be required to offer insurance, to work it must be a plan that management can live with.

Not too good.

Yes, we would have to reduce the number of employees.

Over 17½ would be very expensive - don't know that we could afford.

Added burden of part time employees hence more part time employment.

We now do: some are part of union contracts.

If I'm required to provide these benefits to employees, I'll be forced to hire additional employees, and reduce work hours to each.

Would be very expensive for a small business to compete with the much larger ones in our trade area.

Additional expense would have to passed on to customer. Employees currently not covered (not eligible) would be a higher turnover class of employees. Administrative costs would be significantly higher.

That the employee be require to pay at least 50%.

Not a great impact.

We would have to reduce their wages in order to pay for it.

Our wage scale is enough to cover insurance of their choosing. If we were forced to pay insurance it would cause adjustment and a problem.

Could not do it.

If I had 15 employees, I would have to let one employee go. I could not afford to have any employee take maternity leave for the proposed period of time.

I would have to lay that employee off.

Fortunately we have been able to cover our employees & families. If things got tough it would be nice to have the option of sharing or dropping this benefit if we needed to.

If the cost were to increase much further it could be devestating expecially if you have to cover part time employees.

We currently offer insurance to our employees but the government doesn't need to dictate that we should have to offer it.

Minimal impact.

We pay for all now.

Yes, it would be disastrous.

We currently offer health coverage to all employees after 1000 hours of work for us.

It would hurt! Our % profit would be serverly cut.

If this doesn't include part time, I see no impact.

We provide health coverage to all employees.

The impact would be great, but not a good one. There probably will some abuse on the employees part.

Would cost some additional money. Total employees/workers only 3 so have not had any luck obtaining group insurance.

Another nail in the coffin.

SURVEY CONDUCTED

by

National Association of Manufacturing Opticians

NAMO, initially formed in December of 1975, was formalized by incorporation under the laws of the State of Texas on January 18, 1978. NAMO's membership includes optical laboratories, both national and regional in scope, who provide quality eyeware at a reasonable price within the state-of-the art. Its membership comprises both "manufacturing opticians" and associate members representing a broad spectrum of manufacturers of ophthalmic materials, i.e. lens, frames, machinery. Namo is part of an 8 billion dollar industry.

SURVEY

Health Insurance Coverage

1. Do you provide health coverage for your employees? 100% YES _____NO

2. Do you provide health coverage for their dependents? 90% YES 10% NO

(Please return this survey even if the answer to both questions is NO. Thank you).

3. If you answered YES to Number 1, What is the average premium per employee per month? $ 60.55

4. If you answered YES to Number 2, What is the average premium per family per month? $135.50

5. What share of the premium do you (employer) pay? 50% paid 50%
40% paid 70% (approx)
10% paid 100%

6. What is the deductible? 40% have $100 per employee 50% have $200 per family
40% have $100 per employee 50% have other per family
20% have other per employee __________ per family

7. What is the total monthly insurance payment made by the business? $3497

8. What is the nature of the insurance (e.g. Blue Cross/Blue Shield, HMO, PPO).
33% Blue Cross/Blue Shield 33.3% Self insured

9. What are the principal features of the coverage?

_______Hospitalization/Surgical Only

_______Major Medical Only

100% Hospitalization/Surgical and Major Medical

_______Don't Know

10. How many employees are covered? 131 Average

11. How many additional employees work at least 17 1/2 hours per week?

10 Average

12. Do you provide other benefits?

Paid Vacation 2 Weeks

Life Insurance 90 YES 10 NO

STATEMENT OF
THE AMERICAN CHIROPRACTIC ASSOCIATION
FOR INCLUSION IN THE HEARING RECORD PERTAINING TO
S. 1265, Minimum Health Benefits for All Workers Act of 1987

November 4, 1987

Mr. Chairman, my name is W. Randall Rawson, and I am Director of Governmental Relations for the American Chiropractic Association (ACA). The American Chiropractic Association is a professional organization representing doctors of chiropractic nationwide and presently has a membership of over 20,000.

While S. 1265 contains many worthwhile and laudable provisions, one provision in particular — Section 202 — presently precludes our support for this legislation. As presently written, S. 1265 with Section 202 abridges one of the most fundamental rights of any health-care patient — **THE FREEDOM TO CHOOSE HIS OR HER PRACTITIONER for the purpose of providing the services authorized by his or her health benefit plan.**

Section 202 effectively repeals, nationwide, what has come to be known to many as **state insurance equality laws**. State insurance equality laws are currently applicable in forty-four states. These state statutes require, among other things, insurance companies to reimburse health-care patients for the care they have received by non-MD, state-licensed health-care practitioners in the same manner as the companies reimburse patients under the care of an MD.

The effect of these existing state laws is to assure that health-care consumers may be free to choose state-licensed, alternative health-care providers, in lieu of medical doctors or doctors of osteopathy, with the same assurance that their health benefit plan will equitably reimburse them for the cost of care. These laws, further, insure that insurance companies and other third-party payors, cannot use their patient reimbursement policies to discriminate against any class of licensed health-care practitioner, such as doctors of chiropractic (DCs).

The Employee Retirement Income Security Act of 1974 (ERISA) presently preempts the application of state insurance equality laws to self-insured (self-funded) employee health benefit plans. As a result of a 1986 Supreme Court ruling (Metropolitan Life Insurance Company v. Commonwealth of Massachusetts), ERISA's preemption of state insurance law is limited to self-insured plans; employee health benefit plans underwritten by policies of insurance remain open to state regulation.

The chiropractic profession, on behalf of its present and future patients, has fought diligently for over a quarter of a century to achieve enactment of state freedom-of-choice laws. As a **fundamental right of any health-care consumer**, freedom of choice assures competition in the health care field. It assures that a consumer may choose the health-care practitioner of his or her choice to render already-covered health benefit plan services without a fear that his or her economic well-being will be undercut — because the health benefit plan in question will pay for the services of one type of provider but not for those of another, as-qualified, provider.

We recognize that the operative theory underlying Section 202 of S. 1265 is that because federal law now preempts state regulation of self-insured plans [which constitute 50% or more of the health insurance market in many areas], it makes no sense to have duplicative and contradictory state and federal regulation of the content of health insurance, particularly, so the theory goes, when the states are already barred from effective regulation of a large part of health insurance activity.

Such a theory only renders an existing injustice even more unjust. The basis of this approach is simply heartless — just because the federal government already effectively denies a great many health-care patients any guarantee whatsoever that they may be completely free to choose the type of state-licensed health-care provider they desire, it is appropriate to extend that denial of freedom to all health-care consumers.

We reject this argument and we reject the premise that denial to any health-care consumer of his or her freedom of choice of health-care practitioner is sound policy. We certainly reject any extension of that policy to any more Americans.

The fact of the matter is that there is no duplicative or contradictory regulation between the several states and the federal government when it comes to the guarantees associated with freedom of choice of health care provider. If the states are overriden in their respective efforts to provide freedom of choice to patients residing in those states, there is no federal law to take the place of the overriden state laws.

There may be some confusion associated with the phrase "freedom of choice." Many think "mandated benefits" when they hear the term "freedom of choice." The freedom-of-choice concept cannot be equated in any manner to mandated benefits. It pertains only to the manner in which predetermined benefits are obtained and from whom. Freedom of choice does not mandate a patient's use of any particular health-care provider; it is not a concept that is oriented to the health-care provider. It is a consumer-oriented concept which brings no additional costs to the provision of health-care, but which allows a patient to control who he or she see to obtain already-covered benefits.

S. 1265 would be legislation that the chiropractic profession could support, were it not for the provision repealing the applicability of state freedom-of-choice laws (Section 202).

The American Chiropractic Association has proposed an amendment to S. 1265 that would make the legislation completely supportable by this organization — the amendment is in the form of additional language to S. 1265.

The ACA amendment reads as follows:

> "Section 312 of S. 1265 is amended by inserting the following:
>
> '(d) A health benefit plan shall not discriminate against any class of licensed health care practitioner with respect to reimbursement for the care of any health condition covered by the plan when the practitioner is providing such care within the scope of his or her license.'
>
> "Section 311(b)(1)(B) is amended by adding reference to the above new section to the last sentence thereof, as follows:
>
> 'Nothing in this paragraph shall be construed as not requiring each plan to meet the requirement of sections 312(a)(4), 312(d) and 313.'
>
> "Section 312(a)(2) is amended by substituting 'health care services" for "physician services.' -and-
>
> "Section 323(b)(a)(A) is amended by striking subsection (1), and redesignating the other subsections accordingly."

The above amendment does not interfere with Section 202; it offsets the deleterious effects of Section 202. The above language would provide, in federal law, a guarantee of patient freedom of choice.

The above language would not cause an increase in costs or premiums. The Congressional Budget Office has said [in a July 23, 1986 letter to Congressman William D. Ford, Chairman of the House Post Office and Civil Service Committee] that similar efforts to provide a guarantee of freedom of choice to federal-employee patients covered under Federal Employee Health Benefit Plans, "would have no significant impact on the federal budget." A copy of that letter from the relevant House Committee report is attached for the committee's immediate reference.

If the purpose of mandated-access-to-health-insurance legislation is to afford to those currently without coverage the most functionally effective coverage through the imposition of the minimum of mandated federal benefits, then it would only seem logical that the newly-covered patient should be guaranteed the flexibility to avail himself or herself of the licensed and qualified health-care practitioner of his or her choice to render covered benefits.

Given the record of health benefit plan underwriters -- which prompted the individual states to act in the first place by enacting state insurance regulatory laws -- it would seem prudent that if federal law is to repeal state insurance regulatory law, then the federal law should provide a commensurate level of consumer protection to that being preempted. We believe the above language would accomplish that end.

Is the consumer to be guaranteed — by either state law or federal law, it matters little — her or his right to choose which type of licensed practitioner will discharge covered health benefit plan services? S. 1265 as presently written affords no such guarantee; it actually kills existing state guarantees, providing no offsetting federal guarantee.

A vote for S. 1265 as presently written is a vote against health care patient freedom of choice and against the concerns of alternative health-care practitioners across this country. Aside from the broadside it makes against the patient, it allows third-party payors to "write out" coverage of the provision of services by any praticticoner other than an MD or DO.

If the bill is reported as presently drafted — with particular reference to Section 202 — it will discourage health care competition and leave the patient virtually captive to a limited pool of health care providers because only their services will be eligible for reimbursement.

On behalf of the members of the American Chiropractic Association, I strongly urge the committee to adopt an amendment to this legislation along the lines we have proposed above. Only in this way can this legislation be termed as truly inclusive, competitive and fair.

John E. Watson
Senior Vice President
Governmental & Regulatory Affairs

November 3, 1987

The Honorable Edward Kennedy, Chairman
Committee on Labor and Human Resources
United States Senate
428 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Kennedy:

Please find enclosed the comments submitted by Mitchell Energy & Development Corp. (MEDC) on S.B. 1265, The Minimum Health Benefits For All Workers Act of 1987. I would appreciate your making our comments part of the record of debate on this bill.

MEDC opposes this bill as drafted because of the mandated nature of the insurance coverage that could be provided, and because of the excess cost involved in providing such coverage. We believe that the bill as written, places unfair limits on the amount and type of insurance that employees would have to choose from, and so limits the cost-sharing options that the net result is unreasonable restrictions on an employer's ability to provide other benefit options that an employee may find better suited to his or her needs or the needs of their family.

Thank you for your consideration of our comments.

Sincerely,

MITCHELL ENERGY & DEVELOPMENT CORP.

John E. Watson

John E. Watson

JEW:gnb
Enclosure

MITCHELL ENERGY CORPORATION 2001 TIMBERLOCH PLACE
P.O. BOX 4000, THE WOODLANDS, TEXAS 77380 713/363-5870
A Subsidiary of Mitchell Energy & Development Corp

COMMENTS
OF
MITCHELL ENERGY & DEVELOPMENT CORP.
ON
S.B. 1265
MINIMUM HEALTH BENEFITS FOR ALL WORKERS ACT OF 1987

Mitchell Energy & Development Corp. ("MEDC"), a company engaged in crude oil and natural gas production, transportation, processing, and real estate development, employs approximately 2,500 people. MEDC would be substantially affected by the passage of S.B. 1265 ("the bill"), which would require an employer to enroll all of his employees and their families in a health benefit plan. MEDC opposes a mandated health benefit plan. The bill does not give the employee or the employer a choice in benefits. An employer will be forced to provide these mandated benefits mostly at his expense. The employer will have to use benefit dollars he could otherwise use to fund thrift and savings programs, stock incentive programs, and other company-provided programs employees now enjoy to fund the mandated health benefits. The employee should have a choice in how his benefit dollars should be spent.

MEDC is concerned about the number of uninsured in America. However, MEDC believes this bill does not require "minimum" benefits, but "premium" benefits with most of the cost of such mandated "premium" benefits borne by the employer by virtue of the limitation on employee contribution to 20 percent of the actuarial rate. If mandated health benefits are necessary, there should be greater flexibility permitted in the health care plans offered by the employer and the cost of the benefits should be more equitably shared by the employer and the employee. MEDC has a voluntary employee medical plan which is funded by MEDC and employee contributions. The employees may choose from six medical plan options in three different coverage categories. MEDC believes a medical benefit plan which offers options in coverage will best serve the employees who have varying health care needs. MEDC pays the majority of the employees' health benefit cost. Robert Patricelli, representing the U.S. Chamber of Commerce, has previously testified that the estimated cost of the benefits required by the bill is $1,186 per employee per year in 1988. Conservative estimates in additional cost to MEDC from this bill range from $500,000 to $1,000,000 per year. That cost will, at a minimum, require MEDC to eliminate or reduce other benefits currently offered, such as dental insurance.

MEDC is concerned about who will eventually pay for the benefits this bill, as currently written, will require. The initial cost is to the employer, who will be required to provide the mandated benefits, but that added cost will likely have an adverse effect on workers through lost salary, other compensation, and jobs. The mandated benefits will also affect the economy by making it much harder to start small businesses, especially labor-intensive businesses. Small businesses generate most of the new jobs in the economy.

The bill will require the Secretary of Health and Human Services to set up between six and eight insurance regions and only two to five insurance carriers will be authorized to provide the mandated benefits in each region. Even with the provisions for competitive procedures for certification, periodic evaluation and termination of the certification when necessary, the regional insurance delivery system sets up a monopoly which could encourage higher health costs since unrestricted competition is a key element in keeping prices down. Certification programs are historically difficult to administer and in most instances actually increase the prices they were created to control.

If the bill is passed, MEDC suggests the following changes to provide the employee and employer more flexibility:

(1) The bill as written (i) restricts deductible amounts to the higher of $250 per individual or one percent of annual pay and to the higher of $500 per family or two percent of annual pay, with no deductible for well baby care, and (ii) limits the amount of an employee's out-of-pocket expense to $3,000 or 10 percent of annual salary. MEDC believes these provisions are too restrictive. MEDC believes that an employer should be able to offer these options at actuarially-determinated rates and as an option, plus being able to offer higher or lower deductibles at higher or lower prices to employees. The bill as written provides for rigid cost-sharing by the employer and employee. MEDC believes the employer should be able to offer numerous options in a health benefits plan with flexible cost-sharing with the employees.

(2) MEDC also believes the definition of "employee" should be changed. Part-time employment is growing to meet the needs of the employees and their families. An employer who accommodates part-time employees is confronted with double health care cost. Therefore, Mitchell believes the definition of "employee" should be changed from anyone working 17-1/2 hours per week to a more reasonable limit of anyone working 30 hours per week.

(3) The definition of "30 days of employment" which is used to determine when an employee must be enrolled should be changed from the time an employee first performs an hour of service to 30 days or more of continuous employment as a regular employee working 30 hours or more a week. Eligibility based on less than 30 days of such continuous employment will create an administrative burden for the employer, especially with the COBRA extension the employer will be required to provide.

(4) The bill eliminates pre-existing condition clauses for any disease, disorder or condition. Many employers, like MEDC, share this risk with their employees by limiting payments for pre-exisiting conditions to care necessary following six months of employment. This flexibility should be retained.

MEDC believes mandated coverage is not necessary to solve the problem of the uninsured. As Senator Orrin Hatch testified, "proposals like S.B. 1265, that could cost between $25-$100 billion to address an $8 billion problem, are not the answer." MEDC does not support a mandated benefit program; however, if a mandated benefit program is passed, MEDC urges the Congress to adopt a flexible program. Such a program would allow for options in coverage and for flexibility in cost-sharing between the employer and employee.

National Recreation and Park Association

November 17, 1987

The Honorable Edward M. Kennedy
Chairman
Committee on Labor and Human Resources
Senate Dirksen 428
Washington, D.C. 20510-6300

Dear Mr. Chairman,

On behalf of the National Recreation and Park Association, I would like to share with you our concerns and recommendations on S. 1265, the proposed Minimum Essential Health Benefits Act. I would appreciate it if this letter and the attached materials were included in the record of your November 4 hearing on S. 1265.

Many of our 20,000 members are local park and recreation departments which are concerned about the impact that S. 1265 would have on their ability to provide a diversity of public recreation services. These departments are unique in the array of recreation and cultural programs they provide to their communities. Just a few of these services include summer concerts, day camps, school lunch programs, nature tours and historical events. Traditionally, the demand for these programs is at its peak during the summer months. The workforce of many park and recreation departments more than doubles in size in order to meet this demand. However, a large percentage of the increase is comprised of temporary/seasonal employees who work less than three months out of the year.

In order to determine the effect that your proposal would have on these departments, NRPA developed and disseminated a survey to its membership. The survey requested that respondents provide such information as the number and job status of their employees, and the current eligibility requirements for health coverage.

In compiling statistics from park and recreation departments in over 30 states, NRPA reached some startling conclusions:

1. No respondents currently provide temporary/seasonal workers with health benefits. Further, during the summer months, more than half of their workforce is ineligible for health benefits due to the large numbers of temporary workers hired. Many stated that the administrative costs alone of providing coverage for temporary employees would be burdensome. They also claimed that temporary employees often leave within a few weeks without prior notice. These problems have led most departments to require a minimum number of months of employment

3101 Park Center Drive • Alexandria, Virginia 22302 • *(703) 820-4940*

before a worker (either temporary or permanent) is eligible for coverage. NPRA would urge you to consider including a minimum of six months employment before eligibility for health coverage is allowed.

2. Approximately 50% of the respondents provide health benefits for permanent employees who work less than 40 hours per week. However, none of the respondents provide coverage (with the exception of workmen's compensation) for employees who work less than 20 hours per week. NRPA would recommend raising the minimum number of hours per week from 17 1/2 to 20 hours for permanent part-time employees.

3. Seventy percent of the responding departments provide health benefits packages for permanent employees which contain all the essential elements required by the bill. Those packages not meeting the minimum requirements often do not provide prenatal, well-baby, or catastrophic insurance. Further, many of these departments do not pay 80% of the premium and require employees to pay up to 50% for dependents.

I know you are well aware that local park and recreation department budgets are determined by the governmental entity to which they belong. Each year, a tenuous balance is struck between the needs of the community and its employees, and the extent to which the community is willing to pay for these needs. The park and recreation department of Garner, North Carolina wrote me about their efforts to strike this balance: "We just revised a health care package for full-timers, because of increased costs to the town. We could have reduced payments to reduce the costs to the town, thereby costing the employees directly. We compromised with increased taxes to residents, increased cost to the town, and decreased benefits for the employees..."

This problem, of course, is not limited to our membership, but expands to governments of all sizes.

I urge you to take NRPA's concerns and recommendations into account as you refine S. 1265. If you have any questions regarding our position, please do not hesitate to contact me. Thank you for your attention to this matter.

Sincerely,

R Dean Tice
R. DEAN TICE
Executive Director

Enc.

NATIONAL RECREATION AND PARK ASSOCIATION

Summary of Findings*

PROPOSED "MINIMUM ESSENTIAL HEALTH BENEFITS ACT"

1. **98.5% of responding departments presently provide some health benefits to most, but not all, of their permanent employees.** Those employees not eligible for health benefits were principally persons employed part-time during the year. However, many respondents combined "seasonal/temporary" and "part-time" employment categories. No park and recreation department surveyed provides health benefits for seasonal/temporary employees.

2. **An estimated 50% or more of respondents' total workforce is has seasonal/temporary status and is thus ineligible for health benefits.**

3. **Eligibility for health benefits is typically based on permanent status and a minimum number of hours worked per week.** Responding agencies reported the following hours requirements:

Percentage of total respondents:

49.1% = 40 hours
19.3% = 20 hours
15.8% = 30 hours
7.0% = 35 hours
3.5% = 37 1/2 hours
3.5% = Other
1.8% = 25 hours

Several departments required a minimum number of months worked per year in addition to a minimum number of hours per week.

4. **Health benefits coverage and employee costs are based on fixed rather than variable factors.**

* 84.8% of responding agencies do not base their share of the cost of health benefits coverage on an "hours worked" graduated scale.

* 89.4% of responding agencies do not base their share of the employee benefits on an "hours worked" graduated scale.

5. **92.4% stated that the proposed legislation, if enacted into law, could hurt their financial ability to hire temporary/seasonal employees.** Example comments are in the following section.

6. **70.0% of the respondents report that their benefits package meets the minimum requirements of the legislation for those employees that are currently eligible.** 30.0% say that their package did not meet the minimum requirements for reasons that will be provided in the comments section.

* This summary is based on a non-random survey of state and local public park and recreation departments. November, 1987.

COMMENTS

1. The following are sample comments of the 92.2% whose response indicated that the proposed legislation could harm the respondents' ability to hire temporary/seasonal employees.

"We would probably be forced to limit employees to less than 17 1/2 hours per week, which would make it impossible to recruit and retain employees. Summer jobs for college students would be eliminated, programs curtailed or eliminated, fees and charges increased."

- City of Troy
Troy, MI

"Turnover of seasonal employees is tremendous; some only work two or three weeks and quit without notice... Seasonals would no sooner become enrolled than they would have to be deleted. Paperwork would be virtually impossible."

- Somerset Co. Park Commission
Co. of Somerset, NJ

"First, and foremost, would be increased operating expenses. A portion of these expenses would result from additional medical examinations to be administered and additional personnel required for maintenance purposes... With hiring limitations, the ultimate result has to be cutbacks of programs offered to the community."

- Memphis Park Commission
City of Memphis, TN

"The size and scope of our summer program, Camp Best Friends, would be substantially reduced relative to 1,000 temporary employees hired, 9,000 participants served, and programs offered..."

- Dept. of Parks, Recreation &
Cultural Affairs
City of Atlanta, GA

"Our plan is self-insured and self-administered. Significant increases and decreases in participation due to seasonal employees would required significant additional actuarial calculations to determine appropriate contribution levels."

- Community Facilities
City of Las Cruces, NM

"(Our) cost factor would exceed $15,000 in additional expense. It would mean raising fees, or a real estate tax, or a reduction of seasonal help -- or a combination of all."

-Lemont Township Park Div.
Lemont, IL

2. The following are sample comments by the 30.0% whose health coverage does not fit the minimum standards (eligibility criteria excluded) of the proposed legislation.

"We have exclusions due to health status."

-Neighborhood Club
Grosse Pointe, MI

"We have a pre-existing clause. We pay for employees only; dependent care is available at employee's expense."

- Dept. of Parks and Recreation
  State of ID

"(We) do not pay 80% of the premium."

- Div. of Parks and Recreation
  Co. of Westchester, NY

"...areas of non-compliance are prenatal, well-baby, some diagnostics, pre-existing conditions, employees pay up to 50% of dependents."

- Dept. of Park and Recreation
  Town of Garner, NC

"We do not have catastrophic insurance."

- Dept. of Park, Recreation, & Conservation
  Co. of Westchester, NY

"No maximum deductibles, no provision for full premium payment on low wage workers."

- Div. of State Parks
  State of Indiana

"The county offers various health insurance plans to its permanent employees. At one of them meets all of the requirements of the proposed legislation, with the exception of the catastrophic coverage provision."

- Dept. of Park and Recreation
  Co. of Los Angelos, CA

"Plan provides all mandated benefits except routine well baby care."

- Community Facilities
  City of Las Cruces, NM

3. The following are sample comments on the question: How could the proposed penalty to non-complying states or their political subdivisions affect your department and its functions? (The proposed bill contains language which penalizes non-complying states or political subdivisions by denying them any grant, contract, loan, or loan guarantee offered under the Public Health Service Act.)

"Some of our services to the elderly would be discontinued without grant funding. It is vital to our community to facilitate health care or recreational services to these individuals. Our summer food lunch program would be discontinued. This program provides lunch for disadvantaged children or children who use our recreation centers."

- Dept. of Recreation and Parks
  City of Columbus, OH

"While this agency or this town may not receive direct benefits provided under the Public Health Service Act, the county and state most assuredly do. Therefore, this governmental unit would be forced into compliance or eliminate all part-time, temporary, or seasonal help. (We) just revised a health care package for full-timers, because of increased costs to town. (We) could have reduced payments to reduce cost to town, thereby costing employees directly. We compromised with increased taxes to residents, increased cost to town and decreased benefits to employees. State loss of public health funding might result in decreased services to town taxpayers due to reductions in force or due to disappointed town employees."

- Dept. of Parks and Recreation
Town of Garner, NC

"This department is a subdivision of a municipal government which heavily relies on grants, loans, and loan guarantees. Therefore, the penalty would have a detrimental impact on the city."

- Dept. of Park and Recreation
City of Florence, AL

"Although we currently do not receive funds from the Public Health Service Act, we would be adversely impacted by increased competition for other funding sources by penalized employers."

- Dept. of Park and Recreation
City of Phoenix, AZ

"The penalty would prevent our receiving federal funds for our senior citizen and handicapped citizen programs...which may receive funding through the Public Health Service Act."

- Dept. of Park and Recreation
City of Austin, TX

4. The following are selected personal views on positive and/or negative effects of the proposed legislation.

"Positive in providing coverage for all full-time employees -- if limited to primary employer and a higher minimum hours per week and year-round employees. Negative - low qualifying hours - seasonal loophole - potential dual coverages with multiple employers."

- Neighborhood Club
Grosse Pointe, MI

"Our benefit package is structured to enhance career employment. This proposal would detract from that objective. Government should not be in a position to provide yet another social program, funded by? taxes?"

- Dept. Park and Recreation
State of Idaho

"Permanent temporary employees are, or would be, no problem as far as I see. However, providing this service to seasonal workers could be a waste of Government money and time consuming tasks -- some only work two week and quit."

- Dept. of Park and Recreation
City of Lincoln, NB

"Because our present policy handles this situation for full time, 20 hour employees, a reduction to 17 1/2 hours would not be too disruptive to our operation. However, the proposed bill's neglect to set a minimal time frame which the person must be employed can be drastic, both financially and adminstratively.

- Somerset Co. Park Commission
  Co. of Somerset, NJ

"Unless park and recreation temp/seasonal workers are excluded from the Act as proposed, we'll have the same traumatic adjustments to go through as in California's proposition 13 adjustments...many good professionals will opt for career changes, because of another back-breaking straw. The people will still be served, albeit less effectively until a shakedown occurs and program balances are somehow achieved... I'm hoping that this is perceived as an oversight and the good Senator will rectify it."

- Dept. of Park and Recreation
  Town of Garner, NC

"Our full time employees receive a package of health insurance benefits. Unless the Federal Government shares the cost of catastrophic insurance, this could be very expensive for local governments...Studies seem to indicate that everyone will be using part-time employees more extensively in the future, so this needs to be weighed carefully."

- Dept. of Parks, Recreation &
  Conservation
  Co. of Westchester, NY

WHO RESPONDED?

While all respondents were units which administered park and/or recreation programs, the manner in which the units were organized varied.

The following are the types of administering units that responded to the survey.

9.0% - State Agency
16.7% - County Agency
62.0% - City/Town Agency
6.1% - Park District
6.1% - Commission

WHAT STATES WERE THEY FROM?

Alaska - 1
Alabama - 1
Arizona - 3
Arkansas - 1
California - 2
Colorado - 2
Connecticut - 1
Florida - 1
Georgia - 1
Illinois - 1
Idaho - 1
Indiana - 3
Maryland - 4
Massachusetts - 1
Michigan - 9
Missouri - 1
Nebraska - 1
Nevada - 1
New Hampshire - 2
New Jersey - 9
New Mexico - 1
New York - 1
North Carolina - 1
Ohio - 3
Pennsylvania - 3
Rhode Island - 1
Tennessee - 1
Texas - 2
Virginia - 2
Vermont - 1
Washington State - 3
Wisconsin - 1

NOTE: NRPA received an overwhelming number of responses from New Jersey and Michigan. To keep the numbers balanced, NRPA randomly chose 9 responses from each state. The rest will be sent to the Michigan and New Jersey state associations.

American Dental Association

STATEMENT OF THE
AMERICAN DENTAL ASSOCIATION
ON S. 1265
THE MINIMUM HEALTH BENEFITS FOR ALL WORKERS ACT OF 1987

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

NOVEMBER 10, 1987

Washington Office: 1111 14th Street NW Washington DC 20005 (202) 898-2400

The American Dental Association appreciates this opportunity to comment on S. 1265, the Minimum Health Benefits for All Workers Act of 1987.

The Association has long supported improved access to health care through employer-sponsored benefit programs. Over the last quarter century, we have devoted substantial resources to encouraging employers to provide group dental benefits to workers and their families, and to extend these benefits into retirement and during extended layoffs. This has been done because dental benefits represent the principal proven means of improving opportunities to receive regular, comprehensive dental care.

Today, comprehensive dental benefits are the rule rather than the exception among the nation's larger employers.

In more recent years, the Association's efforts have been directed toward small employment groups. Success here has been limited at best and prospects for future success are not bright. This is principally because of the inadequacies that exist in basic health insurance for many of these workers, conditions that S. 1265 would seek to correct. Until basic health care expense protection is available to all workers, benefits for other needed health services, including dental care, are unlikely to be realized.

These activities illustrate that the Association shares the objectives of this legislation as well as its approach of achieving them through the private sector, in this case the business community. We differ, however, in the method to be utilized. In our view, encouragement of employers to provide this critical protection, through positive tax or other incentives, should be thoroughly explored before considering governmental fiat.

To date, such incentives have not been tested. Even basic equity in tax treatment of all employers has yet to be achieved. S. 1386, companion legislation to S. 1265, would allow full deductibility of health benefit costs to self-employed individuals and owner-operators of unincorporated businesses. S. 1386 has the Association's support.

We believe the Regional Health Insurer system proposed in S. 1265 offers an excellent opportunity to even the smallest employer to obtain basic coverage for employees and should be pursued. Still, even if this coverage were to become available at minimal expense, this "minimal expense" -- certainly in excess of $800 per employee per annum, and considerably more in some areas of the country -- represents a substantial increase in the cost of operating a business, particularly for employers in labor-intensive industries, currently operating on a small margin of profit.

Adjustments in aggregate labor costs in such businesses to compensate for the purchase of benefits stipulated in S. 1265 would most severely affect people now employed at the minimum wage, whose wage compensation could not be adjusted to pay any part of the new benefit costs. The only alternative, if total labor costs were to be maintained at current levels, would be a reduction of this minimum wage labor force, either through terminations or decisions not to hire into available positions. Such "disemployment" has been estimated to affect as many as 100,000 persons, mostly young and disproportiately from racial minorities. Undoubtedly, additional health benefits coverage for 24 million workers and their dependents would create new jobs in the health care field. Those would not be positions, however, that the "disemployed" would be qualified to fill without extensive retraining.

The possibility of this undesirable effect upon the most vulnerable segment of the working class is sufficient reason to examine positive incentives and voluntary compliance.

Among the incentives that we believe warrant consideration are:

- a bonus business deduction, expressed as a percentage of contribution to premium, for small employers

- a tax credit for employers, expressed as a percentage of premium, to offset their internal administrative costs in sponsoring health benefit programs

- a similar tax credit, but weighted in inverse proportion to employer size (e.g., less than 25 employees, 25% of premium; 25 or more but less than 100, 15%; 100 or more, 5%).

The Association offers any assistance it might provide in examining positive incentives of these kinds.

With regard to Section 202 of S. 1265, the Association is most concerned about the effect the preemption of state law would have upon existing benefit programs. The preemption that would be provided under ERISA to insured programs is so wide-ranging that it could create an erosion in the access to care that these programs currently afford.

State laws that protect the program subscriber's choice of practitioner, that prohibit discrimination in benefit programs among practitioners of different disciplines, and that establish solvency requirements for benefit plans, are examples of laws clearly in the public interest and, apparently, irrelevant to the objectives of S. 1265.

If the purpose of Section 202 is to preempt state laws that mandate that specific benefits be provided in all health benefit plans, we believe the section should speak directly to that issue.

The provisions to avoid duplicate family coverage, as stated in Section 302(1) and (2), appear to achieve their purpose only in part. Duplicate coverage of an employed child is avoided by allowing the employed child to waive his or her enrollment when the employed child is covered by a parent's plan. No similar waiver is allowed to an employed spouse. The employee has the option of waiving the employed spouse's coverage and, presumably, selecting coverage for "employees who do not have a spouse but have children," in accordance with Section 314(b)(1)(C)(ii)(III). But, as we read Section 314, there appears to be no requirement that plans offer separate premiums for each of the subgroups identified in the Section. And, in any case, there is no assurance that the total of the premiums for "self and children" and "self only" would not substantially exceed the premium for "self, spouse and children". We suggest that the waiver allowed the employed child be extended to an employed spouse who can demonstrate coverage as a dependent of the other employed spouse.

Finally, with respect to long-term continuation of comprehensive health benefit programs, we are concerned about this legislation's use of the Fair Labor Standards Act, rather than the Internal Revenue Code, to accomplish its purposes.

Federal tax policy as the vehicle for attaining desired health benefit objectives remains under scrutiny in the Congress. The preferential tax treatment of employer contributions to premiums is a mainstay of this nation's employer-sponsored health benefits system. To the extent that Congressional objectives to improve this system rely on this mainstay, preferential tax treatment gains protection for its continuation in law, in that it seems to us unlikely that the Congress would remove the basis for attaining its objectives.

Mandating minimum benefits through labor law, we believe, leaves preferential tax treatment vulnerable to future amendment or rescission.

Thank you for your consideration of our views.

The **Chairman**. The Committee will stand in recess.

[Whereupon, at 12:20 p.m., the Committee was adjourned.]

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